REPORT CARD: ASSESSING ELECTRONIC HEALTH RECORD MODERNIZATION AT THE CAPTAIN JAMES A. LOVELL FEDERAL HEALTH CARE CENTER

HEARING

BEFORE THE

SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION

OF THE

COMMITTEE ON VETERANS' AFFAIRS

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C O N T E N T S

MONDAY, JULY 22, 2024

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SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION,
COMMITTEE ON VETERANS' AFFAIRS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC.

The subcommittee met, pursuant to notice, at 4:30 p.m., in room 360, Cannon House Office Building, Hon. Matt Rosendale (chairman of the subcommittee) presiding.

Present: Representatives Rosendale, Mace, Self, Cherfilus-McCormick, and Landsman.

Also present: Representative Bost.

OPENING STATEMENT OF MATTHEW M. ROSENDALE, CHAIRMAN

Mr. ROSENDALE. Good afternoon. The subcommittee will come to order. I want to welcome our witnesses to discuss the results of an Oracle Cerner Electronic Health Record (EHR) implementation at the Captain James A. Lovell Federal Health Center in North Chicago.

Lovell is the first, only fully integrated U.S. Department of Veterans Affairs (VA), Department of Defense (DOD) healthcare facility in the country. It is also the first large, complex medical center where VA and Oracle have installed the EHR system.

Secretary McDonough approved the go-live on March the 9th as an exception to the overall pause on the Electronic Health Records Modernization (EHRM) program that has been in place since October 2022. That was despite the reset effort not yet producing any game-changing improvements despite the VA pharmacy organization's objections and despite the facility not completing its infrastructure improvements. The results at James A. Lovell tell us a lot.

I want to thank Dr. Buckley for traveling here today to help us understand the reality of the situation. The reality is this is the same system with the same problems that we have seen elsewhere. I commend Dr. Buckley and his team for how well they have managed the challenges and I am glad other parts of the VA have been able to flood the facility with the resources that are necessary just to keep the thing functioning. Their ability to work around the problem is commendable. Make no mistake, despite all the spin,

the problems have not disappeared. As a large complex medical center Lovell has revealed new flaws in the Oracle Cerner EHR.

The committee staff visited James A. Lovell twice and the employees are reporting the same frustration, hypervigilance, and burnout that the managers at the other four facilities testified about last September. They have managed to keep the doors open and provide care to the veterans and service members but only with the support from more than 100 new staff and nearly 100 more on the way.

In addition to the new staff there were nearly 800 experienced users from other military treatment facilities, contractors and experts from the VA central office pitching in immediately after the go-live.

The pharmacy is completely reliant on outside help to operate. The Oracle Cerner pharmacy software functioned so poorly that the permanent pharmacy staff can only process about 40 percent of the prescriptions. They are relying on the VA supplemental staffing unit to handle the majority of the workload. This has all been feasible at one facility. No one thinks it is repeatable or sustainable.

I have serious concerns that the Secretary McDonough is about to put the Department of Veterans Affairs and the veterans it cares for in a dangerous situation by resuming the go-lives on a large scale. If VA is not able to or willing to provide the same level of support they did for James A. Lovell at other medical centers the result could be a disaster. Everyone needs to think seriously about that risk.

The Oracle Cerner EHR is simply not good enough today to enable a bare minimal of efficiency at the VA, let alone the high-quality care our veterans deserve without a huge influx of extra staff and money.

Even before Ms. Duke disclosed that the Veterans Health Administration (VHA) is facing a $12 billion budget deficit, the financial impacts of the EHR on the organization staffing have never budgeted or seriously reckoned with. You can see. We have known for 2 years that the VA's cost estimate is unlikely to hold.

Despite everything that has happened, we still hear rosy predictions from the VA and Oracle and no one has acknowledged the true cost from Mr. Sicilia and Dr. Adirim. They still are testing, professing that this is going to be a $16 billion project and we know it is not. We have learned from Lovell and the previous facilities that the expense to purchase and install the EHR is just the beginning of the cost.

I have no doubt that moving forward with the system before it is fully functional and before the productivity and safety problems are resolved is the wrong decision. It is wrong for the veterans and it is wrong the VA employees.

The Secretary is clearly no longer heeding my warning or this committee's warning. Therefore, the only responsible course of action is to layout the true cost of finishing the Oracle rollout before the VA commits to it. Veterans and taxpayers deserve to know how large the Oracle Cerner bill truly is. Congress as well as the public need all of the information in order to make an informed decision about whether this is worth it and whether the inevitable sacrifices are truly justified. Anything else is a dereliction of duty.

With that I yield to the Ranking Member Cherfilus-McCormick and her opening statement.

OPENING STATEMENT OF SHEILA CHERFILUS-MCCORMICK, RANKING MEMBER

Ms. CHERFILUS-MCCORMICK. Thank you, Mr. Chairman. I thank you, our witnesses, for being here today to discuss the things are going on at VA's newest Oracle health site, the Captain James A. Lovell Federal Health Care Center or FHCC.

It has been just over 4 months since FHCC went live with Oracle's Millennium EHR. By many accounts this go-live has been VA's most successful to date.

While it may have been more successful than previous attempts I think we are far from ready to endorse further go-live activities. FHCC had the luxury of being the sole focus of both VA and DOD's EHR modernization programs. The two departments threw more resources at this go-live than ever, than will ever be available at any future VA facility.

Regardless of how successful the implementation at FHCC may have been, there are still many issues that need to be addressed. We recently learned that the pharmacy fixes, titled 3b/3c, will not be rolled out until spring of 2025. These are meant to address issues that were identified years ago.

We have heard from pharmacy managers that without these fixes the workload required to keep veterans safe is unsustainable. I would really like to understand what is taking so long to get these issues fixed. Another longstanding issue, it has been 4 years since the first go-live at Mann-Grandstaff and training and change management are still not meeting expectations. VHA staff are still not brought into the standardized workflows and are trying to modify the system to match what they are use to.

I reiterate my concerns that the VA is still attempting to standardize its workflows and equipment and standards while they are actively deploying a new EHR. This really should have been done first and I suspect it will continue to cause problems with the deployment until these standardization decisions are made.

Also, the facilities using Millennium are still far too reliant on workarounds. I am concerned that the need for workarounds indicates that there are systems still is not fully functional or staff are refusing to use the system as designed. I would like to know which one is it?

It also seems like the workarounds are not being centrally managed. I have heard that staff at individual facilities are creating own and not communicating them up through the Electronic Health Record Modernization Integration Office (EHRMIO). I feel we are headed for a situation where every facility is using the system differently which is contrary to the standardization goals of this project and runs the risk of continuing the reality that if you see one VA, you have only seen one VA.

We really should not allow that to happen. Fractured or segmented care is not the best, is not in the best interest of veterans. Since FHCC is the first level of one VA facility to go live with the new system, there are new issues that have been raised. Specifically, there are several issues that FHCC and staff raised that

upon further investigation it came down to providers not entering orders correctly, which is creating way more work downstream for the lab, pharmacy, and referral management.

I would like to understand why this continues to be an issue and what VA is doing to fix it. I suspect that is some how got something to do with providers' complaints that the system is not intuitive and that it is not user friendly and that it makes, that it takes far too many clicks to accomplish their work.

I am concerned that Oracle does not seem to be acknowledging these complaints and addressing their usability shortcomings. This is not a new complaint. EHR users have had these complaints for almost as long as EHRs have existed but this lack of usability has caused VA to need to hire considerably staff to accomplish some of the same tasks.

I am concerned that these extra manpower needs will have a dire impact on VHA's budget, that the need for facilities to hire more people to do the same task will limit their ability to fill other vacancies. This could have a disastrous effect on veterans' access to VA healthcare and will lead to further expansion of community care. We cannot allow this happen.

There are valid reasons for community care but understaffing should not be one of them. It is our responsibility to ensure that there is a VA for future generations of veterans. For us to do that Oracle must take a hard look at how overly cumbersome its system is and solve the usability issue.

I look forward to hearing from our witnesses today and I yield back.

Mr. ROSENDALE. Thank you, Ranking Member Cherfilus-McCormick. I will now introduce the witnesses on our first and only panel this afternoon. First, from the Department of Veterans Affairs, we have Dr. Neil Evans, the acting executive director of the Electronic Health Records Modernization Integration Office.

We also have Dr. Robert Buckley, the director of the Captain James A. Lovell Federal Health Care Center. Next we have Ms. Laura Duke, the chief financial officer of the Veterans Health Administration. Finally, we have Hon. Ms. Seema Verma, executive president of Oracle Health and Oracle Life Sciences.

I ask the witnesses to please stand and raise your right hands.

[Witnesses sworn.]

Mr. ROSENDALE. Dr. Evans, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF NEIL EVANS

Dr. EVANS. Chairman Rosendale, Ranking Member Cherfilus-McCormick, and distinguished members of the subcommittee, thank you for this opportunity to testify again today about VA's initiative to modernize its electronic health record system.

I am accompanied, as was just mentioned, by Dr. Robert Buckley, executive director of the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois; and Laura Duke, chief financial officer for the Veterans Health Administration. I want to thank Congress and this subcommittee for your shared commitment to veterans and for your continued support of VA's modernization efforts.

As has been mentioned today, we are here to discuss the deployment of the Federal EHR to Lovell FHCC, our progress with the EHRM program reset, and VA's plans to move toward restarting deployment activities in the coming year.

As you likely recall, the current EHRM program reset was announced in April 2023 with three primary goals: number 1, to address the concerns of the live sites; number 2, to invest in foundational work necessary for long-term success of the program at the enterprise level; and number 3, to prepare for and successfully deploy the Federal EHR at Lovell FHCC.

A little less than a year after that announcement, in collaboration with our partners and DOD and FEHRM, VA realized one of those goals by launching the EHR at Lovell FHCC on March 9, 2024. We continue to support and closely watch progress at Lovell FHCC.

At this point it is still too early to declare unequivocal final success, but results have been promising overall. There have been no critical patient safety incidents as of today. Lovell FHCC maintained 100 percent capacity for its Emergency Room (ER) and inpatient bed census throughout the deployment.

Outpatient productivity is up to approximately 80 percent from a 50 percent reduction for go-live and acute medical and Intensive Care Unit (ICU) care has returned to baseline.

The leadership and staff at Lovell FHCC should be commended for their success. They have demonstrated tenacity and a continuous commitment to successfully adopting the new electronic health record to care for the veterans, Navy recruits, DOD beneficiaries, and others who are served by their organization.

Progress toward achieving the other two reset goals, addressing issues identified by the live sites and improving our enterprise processes to support the Federal EHR, continues. For example, more than 1,500 configuration changes have been implemented in the past year to improve the experience of end users at the live sites.

From July 2023 through May 2024, VA resolved more than 1,000 aging incident tickets and resolved the vast majority of its provisioning backlog. We have seen the core EHR increasingly stabilized, resulting in significant improvements to the user experience. We were able to introduce new methods for training users as part of the Lovell FHCC go-live, which were well received and are informing further changes in our training and adoption approach.

A new process for effectively managing configuration changes for the system, one that will better support adherence to best practices for use of the EHR, enforce adherence to national standards, and better leverage our informatics workforce at both the site and Veterans Integrated Service Networks (VISN) levels is currently being implemented and more.

While we have seen measured and meaningful progress several improvements that are important for long term success require revisiting decisions made early in the program through the lens of lessons learned by the DOD, VA, and the best practices of other Oracle Health customers. These projects are more significant than a simple fix and are being referred to as "big rocks" given our

prioritization of these efforts and because of the complex scope of the tasks.

Some of these involve revisiting the approach to our referral management, further improving training for new users, standardizing and consolidating user roles, and the system delivering a key pharmacy capability known as Pharmacy 3b/3c and more. In parallel, other reset workstreams continue with their focus on process improvements that will support the big rock efforts, increase the pace of change, and move the program toward restarting deployments.

Although it is still too early to discuss concrete plans for resuming deployments, VA remains committed to exiting reset and restarting deployment-related activities in Fiscal Year 2025. I should emphasize, however, that the continuous improvement efforts that have been our focus during the reset will continue even after we restart deployment-related activities.

Our restart is not a binary toggle from improvement efforts to the pursuit of deployment efforts, but instead is additive. We will restart deployments while we continue, that is deployment activities, while we continue our support for our current users and our system optimization efforts.

Wrapping up, with the activities now underway and considering our progress to date, VA leaders are optimistic about a path forward toward full implementation of the Federal EHR throughout VA and we appreciate the partnership of Congress as we pursue that goal.

Thank you for your commitment to serving veterans with excellence and for your interest in and oversight of this program, and we look forward to responding to your questions.

[THE PREPARED STATEMENT OF NEIL EVANS APPEARS IN THE APPENDIX]

Mr. ROSENDALE. Thank you, Dr. Evans. The written statement of Dr. Evans will be entered into the hearing record. Dr. Buckley, you are now recognized for 3 minutes to deliver your opening statement.

Dr. BUCKLEY. Thank you Mr. Chairman. I was not asked to actually prepare formal written statements so I will take this opportunity, though, to thank everyone and say this has been a great opportunity on behalf of the Captain James A. Lovell Federal Health Care Center, as you mentioned, our Nation's only fully—joint fully integrated defense and veteran healthcare that is led by the Department of Veterans Affairs and that partnership.

This opportunity to have a single, integrated electronic health record is the opportunity that this facility has been waiting for, close to 15 years. We have benefited from it already in many ways. There has been—there is certainly been challenges along the way and opportunities to learn from, but I can tell you this, our staff understand the value that brings to all of those entrusted to our care, to our veterans, but also to all those that will someday be veterans and then their family members as well.

I can tell you I would characterize our journey so far, I am going to say it is going very well. I am going to say it is going better than anyone expected and I am going to say that because we have a phenomenal staff. We have staff that are committed to being a high

reliability healthcare organization to use whatever tools we need to make sure that our patients get the very best care possible and we are leveraging this new electronic health record to make sure we meet those ends.

We are also wanting to—my staff are also fully focused on becoming the facility, the first 1c, level 1 VA medical center and the only, as I mentioned, joint DOD and veterans medical center to have the opportunity to learn how this new electronic health record functions, learn the workflows, learn the technical aspects and many that still need to be improved, certainly I agree with you.

I would just say that our people are to be commended, our staff I believe are to be commended, and then our partners, we have had great partners, and when I mean that, I mean from within the VA itself. You have mentioned there is been a lot of support that we have gained, a lot of short-term staffing support that has really been helpful for this particular, this particular unique deployment that had lots of things that needed to be addressed.

It is good to have that extra subject matter expertise at your side when you go through this and we have benefited greatly by the support that we have gotten from within the Department and within the DOD as well. There was a lot of great support across the departments.

Then I would finally say our partners at the Oracle Health, Cerner, Federal EHR, our Oracle partners I think are really starting to show some signs of improvement and being attentive to some of our needs to change for both engineering changes as well as just changes to configurations and then the assistance to help our workflows become better and better.

With that, I think that is kind of our take on it so far, sir.

Mr. ROSENDALE. Thank you very much. Ms. Verma, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF SEEMA VERMA

Ms. VERMA. Chairman Rosendale, Ranking Member Cherfilus-McCormick, and members of the subcommittee, thank you for the opportunity to speak with you today. This is my first time to appear before this committee since joining Oracle.

I took over as the general manager of Oracle Health at the beginning of the year and I am very pleased with the progress we have made not just this year, but overall in the 2-years since Oracle's acquisition of Cerner. As general manager of Oracle Health I am excited about the opportunity to bring a higher level of quality, efficiency, and better outcomes to veterans who have served our Nation and fought for our freedoms.

We are proud of the first deployment of the system under Oracle's ownership with go-live in March 2024 at the Captain James A. Lovell Federal Health Care Center in North Chicago. Four months later, we continue to be highly focused on it to be certain that our initial success endures. Training was critical to this effort and we are grateful to the Lovell users who are attending training and making it a priority. Lovell was the first site where we used learning labs and so that end users could work as a comprehensive care team to understand the needed workflows.

The learning labs were first piloted at Lovell in December 2023 for a small group of 54 superusers. Based on the overwhelmingly positive feedback, VA asked us to expand their use and we quickly stood up an additional 55 sessions for more than 200 end users.

All of this led to Lovell's users demonstrating faster adoption rates and less time spent in the EHR than any of the other previously live sites. We believe that this will contribute to better end user satisfaction.

At Lovell emergency department average weekly patient volumes increased by 14.5 percent over pre-deployment averages with total length of stay averaged decreasing by 7 minutes. Ambulatory patient volumes range from 70 to 90 percent of pre-deployment levels, which is consistent with other complex facilities 4 months into a go-live.

As Lovell strives to ramp up all department volumes to 100 percent by this October, we will continue to provide in-person, onsite support for users. Other updates that we have made both recently and over the last 2 years have resulted in significant improvements across all live sites.

Most importantly, the system reliably runs without outages.

We have made approximately 1,500 configuration changes and 88 workflow updates to simplify the end user experience. We are connected with 90 percent of community care providers, which provides for better coordination of care. We are working with the VA on improving productivity and revenue collections at the live sites, which, of course, were impacted by the Change Healthcare cyber attack.

We are pleased with the progress VA has made to streamline governance and decision-making and their ongoing commitment to this effort which will be critical toward driving a consistent standard of care in completing additional enhancements to improve the user experience.

In addition, we are planning to move the system to the cloud at our expense. Moving to the cloud will provide even better cybersecurity protections and allow VA to bring forward innovations, like our AI-driven, clinical digital assistant to help providers take advantage of modern technology, to spend more time with veterans and less time-on-time consuming data entry.

We strongly believe the success of Lovell and the cumulative effect of the various improvements delivered to the five sites during the reset, including technical performance, workflows, training, pharmacy, support and clearing tickets, and more, provide the proof that the VA needs to implement the new EHR to additional facilities with confidence.

In parallel to ongoing enhancement efforts pre-deployment work at future sites should restart this fall and new deployments at those sites should be planned for next year. Oracle's ready to get restarted and to bring the benefits of this new EHR to move more veterans, to more veterans across the country.

Thank you. I look forward to answering your questions.

[THE PREPARED STATEMENT OF SEEMA VERMA APPEARS IN THE APPENDIX]

Mr. ROSENDALE. Thank you, Ms. Verma. The written statement of Ms. Verma will be entered into the hearing record.

We will now proceed to questioning and I will recognize myself for 5 minutes of questioning.

Dr. Buckley, your facility's performing better with the Oracle Cerner EHR than the previous five medical centers. This seems to be because of your hard work and a lot of outside help, not improvements to the system.

I understand you have got a temporary support from nearly 800 people and you are on track to add at least 216 staff at a cost of $26 million annually. Could you operate without these resources and how would the system need to improve so you no longer need those resources?

Dr. BUCKLEY. Thank you, and I think that is a fair characterization and summary. I tell you I think it is necessary for being the first site to go live in a couple of years that we had those resources brought alongside of us to make sure it was as successful.

We are learning that over time that the amount of staff that it will take does not appear to be quite as large as what you have just quoted. I cannot give you the exact number at this point.

Mr. ROSENDALE. You do not have a request in to get an additional 100 staffers?

Dr. BUCKLEY. We currently have a total of well over 200.

Mr. ROSENDALE. Do you have a request in right now to get an addition 100?

Dr. BUCKLEY. We have the—yes, sir. We have the authority to hire to that, but what I am saying——

Mr. ROSENDALE. Things clearly then, Dr. Buckley, okay, things are clearly not functioning exactly right or you would not have requested for an additional 100. Could you operate—could you currently operate without those resources and how would the system need to improve so you no longer need those resources?

Dr. BUCKLEY. Well, I can tell you, yes, I think we could. I can tell you this——

Mr. ROSENDALE. Can you operate without those resources?

Dr. BUCKLEY. Not—we cannot operate——

Mr. ROSENDALE. Okay.

Dr. BUCKLEY [continuing]. and to meet the needs of both departments to make sure we are delivering the care——

Mr. ROSENDALE. Okay. You could not——

Dr. BUCKLEY [continuing]. and learning.

Mr. ROSENDALE. You could not operate without those resources?

Dr. BUCKLEY. That is right.

Mr. ROSENDALE. Correct?

Dr. BUCKLEY. That is why we are asking for them, the authority to hire, Chairman.

Mr. ROSENDALE. Okay. What would need to change, what would need to improve so that you do not need those additional resources?

Dr. BUCKLEY. Yes, sir. One of the things is over time learning the workflows within the Oracle Health, Cerner, Federal EHR. That is a—that is a hard task and that takes time and that takes time for each facility. I think it will—as we——

Mr. ROSENDALE. Okay. How long are you anticipating you are going to need these additional resources?

Dr. BUCKLEY. What we are looking at right now—and I do want to talk about resources if given the opportunity. Our staffing, one thing to be clear is while it may——

Mr. ROSENDALE. Dr. Buckley, this is my time. I have got 2–1/2 minutes.

Dr. BUCKLEY. Oh, yes, sir.

Mr. ROSENDALE. Please, Okay, how long are you anticipating you are going to need these additional resources?

Dr. BUCKLEY. I would say to the end of Fiscal Year 2025.

Mr. ROSENDALE. Okay. By the end of Fiscal Year 2025 then, when we start working on the appropriation bills, then we are going to be able to make an adjustment so that these additional resources are not directed?

Dr. BUCKLEY. I think we will be——

Mr. ROSENDALE. We are not going to hear complaints from you or your employees?

Dr. BUCKLEY. Well, I, you know, I complain a lot.

Mr. ROSENDALE. I have got a chart back here where everyone was telling me that we are going to stay within the $16 billion and we clearly are not going to be able to do that. Dr. Buckley, you had 808 joint patient safety reports 3 months after Oracle Cerner went live. How crucial are these additional employees to mitigating the system's safety risks?

Dr. BUCKLEY. Well, I think the more focus that everyone has on being a higher liability healthcare organization the better. I do not necessarily think throwing more staff at a problem is the solution.

Mr. ROSENDALE. Right. That means we are going to be able to start reducing——

Dr. BUCKLEY. I think——

Mr. ROSENDALE [continuing]. the staffing then?

Dr. BUCKLEY [continuing]. in time, in time I think we are——

Mr. ROSENDALE. Can I then——

Dr. BUCKLEY [continuing]. going to be able to do that.

Mr. ROSENDALE. Or can we expect that you are going to remove that request for the additional 100 staff that you have outstanding now?

Dr. BUCKLEY. No. Like I said——

Mr. ROSENDALE. Okay. We still do need staffing then? Dr. Buckley, you described your facility's experience using the Oracle Cerner EHR to the committee staff as a pitched battle but prevailing. What makes it a pitched battle and how are you prevailing?

Dr. BUCKLEY. Well, I would say health delivery is a pitch battle every day because we can never, ever be fully at the place where——

Mr. ROSENDALE. Okay. How about your facility with the rollout of a new software program, why is that a pitched battle and how are you prevailing?

Dr. BUCKLEY. Well, I would say that adoption of a new health record and a change of this magnitude is, no kidding, hard. It really is hard. I think our staff know that the battle is worth it in the long run, that this is going to deliver the conditions for standardization that the VHA needs, and that modernization is something we need in order to reach standardization.

Mr. ROSENDALE. Thank you very much, Dr. Buckley.

My time is expired and I will now recognize Ranking Member Cherfilus-McCormick for 5 minutes of questioning.

Ms. CHERFILUS-MCCORMICK. Thank you, Mr. Chairman. Dr. Buckley, Oracle's testimony paints a fairly rosy picture of pharmacy at your facility, but when my staff was there in June they heard very different things. How are dispensing values and wait times now compared to pre-go-live?

Dr. BUCKLEY. Thank you. That is a great question about the pharmacy. I will say, I would—I do not think "rosy" is a great word, but I think that acknowledging our pharmacy staff at Lovell FHCC in North Chicago is worth mentioning. They have been tenacious in understanding what the requirements would be.

This is a lot hard. Remember this is two separate pharmacy benefits, two separate formularies dispensed side by side.

The challenges, and pharmacy is probably the biggest one, the challenges to modernizing with this, this health records, are pretty substantial.

I was surprised how well this Federal EHR was actually able to perform when it was delivered.

Ms. CHERFILUS-MCCORMICK. Now you mentioned your staff. About how many staff members did you have to help you get to this level?

Dr. BUCKLEY. Well, when we started pre-deployment we had, I will say, roughly 140 full-time pharmacy and pharmacy techs. I will say actually right now we have actually less full-time pharmacists and techs onboard right now than we did when we went live.

Ms. CHERFILUS-MCCORMICK. What was your maximum amount? You said when you started you were at 140? What was your maximum amount?

Dr. BUCKLEY. Right. I am going to have to take that one for the record to say precisely how many additional staff. If we are looking for part-time, additional Full-Time Equivalent (FTE) toward that helps with that, we have benefited from NESSU, the National EHRM supplemental staffing unit. They are providing, I will say, roughly four to five pharmacy FTE per day and that is the additional value that they bring for outpatient. What our——

Ms. CHERFILUS-MCCORMICK. What would be a total range?

Dr. BUCKLEY [continuing]. outpatient turns——

Ms. CHERFILUS-MCCORMICK. Your total range of staff that it took for you to actually achieve this result?

Dr. BUCKLEY. I would have to get the top value on that from pharmacy itself. I would look to where it was somewhere less than total staff of 150.

Ms. CHERFILUS-MCCORMICK. Dr. Evans, we are hearing that the 3b/3c upgrades have been pushed to next spring. We are hearing from pharmacy staff that these solutions are desperately needed. Why have these fixes take so long?

Dr. EVANS. We are anticipating that the pharmacy, what is known as the pharmacy 3b/3c upgrade, this is the capability that will keep the ordering, the systems that providers order prescriptions in sync with the system that pharmacists fulfill the prescription in. That is, it is going to be delivered February 2025.

Ms. CHERFILUS-MCCORMICK. Why has it taken so long?

Dr. EVANS. I think in some ways, you know, it was delivered numerous months ago and there were findings on testing prior to deliver of the 3b/3c capability where a subset of what we expected the synchronization to do did not work. A small amount, but a significant amount. We made the decision to not deploy it until it was as we wanted. We spent a lot of time really getting to——

Ms. CHERFILUS-MCCORMICK. When did—I have another question, so I just want to get to this.

Dr. EVANS. Yes.

Ms. CHERFILUS-MCCORMICK. When did you provide VA—when did VA provide Oracle with the requires to fix these issues?

Dr. EVANS. We had a joint meeting that was I think a few months ago, a month and a half ago or so, where we sat down actually at the facility in FHCC and national pharmacy leadership——

Ms. CHERFILUS-MCCORMICK. Thank you. Dr. Verma, from Oracle's perspective what has been the hold up in fixing these issues?

Ms. VERMA. Sure. Well, just to give some context of the whole pharmacy solution, right, so the way that the pharmacy operates is very different than what we see at most commercial sites and so it is required some unique confirmations.

VA had asked us to focus on pharmacy in particular. There was seven enhancements that they asked us to make. We delivered six out of those seven. We thought that they would take much longer, but they were actually delivered in a year and half, which was much quicker than originally anticipated.

We thought it may take 3 years, but we were able to deliver that quicker.

In terms of 3b/3c, we did deliver a solution, as Dr. Evans indicated. I think through testing there was the thought from VA that maybe a different design would be better. We have been working together.

I think the teams went through requirements and redesigned something that we think will work better and that will be delivered early next year.

Ms. CHERFILUS-MCCORMICK. Thank you so much. I yield back.

Mr. ROSENDALE. Thank you very much, Ranking Member Cherfilus-McCormick. I now recognize Representative Self for 5 minutes of questioning.

Mr. SELF. Thank you, Mr. Chairman. Dr. Evans, I will be honest with you, I have been asking, we are talking about tactical issues here, symptoms, how fixes to things happen. My questioning on this system, I have asked where is the value proposition because it normally is savings costs over time, supplies, maintenance, sustainability, and nobody can tell me what the value proposition is.

Why are we doing this? Now, in your own testimony there was some very soft phrases which should over time positively impact patient care, quality, and safety, more coordinated experience for VA staff and clinicians, improved operability with the rest of the American healthcare system, and then what looks to me, and you make a big point out of it, transitioning from DOD to VA, but that looks to me to be a one-time event for most people. Do you use lifecycle cost analysis?

Dr. EVANS. Yes.

Mr. SELF. How are you accounting for all of these personnel that you are adding in your initial way back when, your lifecycle cost analysis? Let me just refresh you. We are at $35 trillion in national debt today.

Every dollar in discretionary spending, every one, all those that we vote on, 12 appropriations bills, every dollar is borrowed in discretionary. You have got a $12 billion shortfall, 15 across VA.

You tell us that something on the order of $50 billion is going to take to roll—finish the rollout here in 2038, I think is what you say. I think most Information Technology (IT) systems, everybody knows that once they are deployed they are by that time overpriced, obsolete, and behind schedule.

What is it going to cost us to finish this rollout with a complete lifecycle analysis?

Dr. EVANS. When this program first began there was a lifecycle cost estimate. That is where the $16 billion number comes from that was referenced earlier. That includes a significant investment in infrastructure that was necessary to run the electronic health record. In that lifecycle cost estimate we also did not include costs for the sustainment of the system over time.

Mr. SELF. Well, why not, because sustainment, when you buy an aircraft or a tank or anything, sustainment is a major part of the lifecycle cost analysis.

Dr. EVANS. Right. There was—and you have referenced a number, a higher number that was based on work that was done by Institute for Defense Analyses (IDA), a separate lifecycle cost estimate outside the program, which did include sustainment costs and, frankly, a longer tail to the lifecycle cost estimate.

What we have said is that we agreed that a lifecycle cost estimate is critical for this program. At this point in time without a deployment schedule it is hard to deliver a revised lifecycle cost estimate. One of the things that we have said that it is part of this reset as we move toward restart and a new deployment schedule that we would deliver a revised lifecycle cost estimate.

Mr. SELF. You started with $16 billion. We are, however, many billion in it now, $9 billion or something with another, staring down the barrel of another $50 billion.

Dr. EVANS. I do not know where the number $50 billion comes from, but I think that this is part of why we do need to, as part of the reset, understand what the lifecycle costs are going to be as we move forward.

Mr. SELF. There are estimates, apparently there have been estimates done that in some of the live sites, we have got to go quickly here, we are looking at 20 percent in some of the live sites. We were looking at a 7 percent increase.

If we go with the high end of that, it would be $10 billion more that is not accounted for. If we went to the low end, it would be $3 billion more. I am going to be curious in the future rather than talking about these tactical issues, these fixes on the things that we see in front of us, where are we going strategically with this thing? I just—I do not see the value proposition over the life of the thing.

We have got—and Dr. Buckley here, as he eloquently said, he commands the—he leads the only integrated site. I do not think

that is even a good test bed for us to go to the single site that has the very successful DOD program and the less successful VA program.

With that, Mr. Chairman, I yield back.

Mr. ROSENDALE. Thank you very much, Representative Self.

I now recognize the chairman of the full committee, Representative Bost, for 5 minutes of questioning.

Mr. BOST. Thank you, Mr. Chairman.

Ms. Duke, over the last weekend Congress received a request for supplemental funding to cover the benefit shortfall that VA expects in September. When you put the supplemental funding request for healthcare next year, should not it address the staffing costs related to EHR?

Ms. DUKE. It does assume a higher level of staffing for numerous purposes to include the emergent needs of the go-live sites.

Mr. BOST. Okay. VA has been indicating since February that there may be a healthcare budget shortfall driven by community care. Community care only accounts for $1.8 billion of the $12 billion shortfall you say you have. When did you realize you had a much wider shortfall on your hands?

Ms. DUKE. When did we realize? I would say when we were monitoring FTE counts beginning in the January time period as we started to watch where the staffing levels were and when the staffing levels were coming in higher than what we were targeting.

Similarly, the year-over-year growth of community care obligations was higher than what we had projected at the time of the budget.

Mr. BOST. That was not given to us. We kept hearing that we are fine, we are fine, we are fine, we are fine. How much of the $12 billion estimate shortfall is due to hiring?

Ms. DUKE. Is due to hiring? Hang on, let me pull the number. It is roughly around $3 billion.

Mr. BOST. Okay. How much is the medication shortfall and the prosthetic shortfall and what exactly is driving those costs up?

Ms. DUKE. In the $5 billion—or excuse me, in the 25 period we have seen an increase prosthetic and the costs that are actually being paid by our facilities. We put in I think it was $3.9 billion and to assume a higher level in 2025 that is associated with those costs. We are still diving into those costs to see what is driving them.

Mr. BOST. Ms. Verma, I have got another question for you and not so much a question, but just a statement. When this all was going on and I was ranking member, not yet chairman, and we were watching Cerner blow apart, okay, Oracle came in and they made their purchase and they came into my office and they had about three or four executives. It was not the primary, but a lot of the upper echelon.

Now, you told me that—or you told us just now about the pharmaceutical, that there was seven unique situations put before you. You get six of them done and then you did in 18 months.

Now, I am going to tell you exactly what your executives told me in that room whenever they were taking over for Cerner. If a person tells you in this industry that they cannot fix a problem in 6

months, they do not know what they are doing. That was their exact words. I wrote it down.

You are telling us to fix the situation with the shortfalls and the problems that have occurred in the pharmacies. You have been working on it in 18 months, a great thing because you got six of them done.

Every time we turn around—and I have said this before. The frustration level that I have felt and being on this committee, whether—and through two administrations now, and the lack of being able to get this done—and I have to agree with my colleague, Mr. Self here, that comparing to where DOD is already working and then being able to wave that as a flag that you are doing well, when every other one that strictly deals with VA has failed and failed miserably, and the only reason DOD—the only reason that Great Lakes and that area was done is because they offset it with staff that they used through DOD to help them get it done.

This is very difficult trying to do our fiduciary duty every time we call you guys in and we cannot—we keep getting one reason after another after another after another that we cannot get things done. Now that was directed at you.

I do not need you to answer the question. I am just telling you the things and the frustration that we are feeling. I am going to leave it to the rest of the committee to keep asking questions. I do not know how to fix it because we are so far down the road that we cannot put on the brakes.

The bad thing is it should have been very simple to adjust and now here we are not slightly over budget, way over budget. We only have six facilities even started to be turned up. This has been a boondoggle from the very beginning and I am very disappointed.

With that, I am running out of my time and I yield back.

Mr. ROSENDALE. Thank you very much, Mr. Chair. I appreciate you joining us today.

We are going to go to the second round of questions and again I will recognize myself for 5 minutes.

Dr. Buckley's VA testimony states that you are 70 percent of normal outpatient productivity since implementing the EHR. Dr. Evan's stated 80 percent. We have a discrepancy there about who is using what numbers. Where are you exactly throughout the whole hospital today?

Dr. BUCKLEY. Through the whole hospital, if you looked in our—what I will call the inpatient, as I said, side of the house, so the bedded part of the facility, the ED, the Operating Rooms (OR), I would say we are upwards of over 95 percent reduction in those areas.

Our 32-bed locked psych unit has been at 100 percent since go-live. Our med-surg unit and ICUs are now virtually at 100 percent capacity. I think we are one or two beds down still. Our ED, as we mentioned, was never missed a beat to go-live.

I would say in those areas, if we mix that with the outpatient, those—the ambulatory clinic visits, we are sitting right at about 80 percent using the focus metrics that have been provided.

Mr. ROSENDALE. Okay. If we are sitting at 80 percent on the averages and you are telling me that you are at 90 to 100 percent

for your inpatient, then the outpatient must be dramatically lower than that.

Dr. BUCKLEY. No, sir. The average of the outpatient, if I misspoke I apologize, the average of the outpatient that we are—that is being given to us right now where we are sitting is roughly 80 percent. There are some areas that are—some clinics that are less than, you know, around 70 percent or less. There are some that are well over 90 percent in the clinic environment.

Mr. ROSENDALE. Okay.

Dr. BUCKLEY. Where we are sitting now is about 80 percent in outpatient, close to 100 percent everything else, and that does not include the DODs. Remember we are the lead agency. We, unlike what Chairman Bost said, the DOD did not give us extra staff. We have less staff from the DOD. That bill comes to us and then we have to bear that, and hopefully we will——

Mr. ROSENDALE. Okay. I understand your staff had the same basic struggles with the Oracle Cerner system as the other medical centers employees. That is the feedback and the report that we received. On top of that, yours is the first large complex VA facility to go live Thus, has revealed some new problems. Will you please explain the patient movement problem?

Dr. BUCKLEY. I will do the best I can, sir. The Oracle Health Cerner model has what is called an encounter, a Financial Identification Number (FIN) number, a financial number that gets attached to the patient when they first enter what the inpatient environment.

Those inpatient environments, not only the meds, you know, a hospital, inpatient hospital unit, but it could also be our Community Living Centers (CLC), our skilled nursing facility, it could also be our residential substance abuse treatment areas. Those all are called, those all entered under the same FIN. and when that patient moves around the facility and typically in a private sector environment, they would go from an external facility to a new—to a facility that might be using Cerner.

They would get a FIN and they would work through that acute visit and then go home, go back to the nursing home, go back to their rehab, go home. In this case that FIN has been—it follows them around and we have to be extra mindful that there are—that the beds need to be secured for them, there needs to be standing orders that get held in a leave of absence status, so that causes a lot of strain.

The good news is that, you know, partnering with the program office and VHA, we are really coming up with the best policy for the agency to address this problem because, frankly, the DOD did not have this problem. There is a lot of complexity that the DOD does not have to struggle with and this is a great example of one.

Mr. ROSENDALE. Okay. Please explain the situation with the power plans which are basically templates and checklists in Oracle Cerner that are supposed to save the staff time?

Dr. BUCKLEY. Yes, sir. I think the long and short of it is that power plans are order sets that are best done when there is clear standardization and that it comes from, you know, the councils and program offices that understand what orders need to be provided and which do not.

This is really something that is probably one of the best things that this modernization can do is to bring standard order sets, standard power plans across the organization and so that when you do not—when you go to VA, you can could go to another VA and still sit down and have the same choices to choose from or when you write orders for a typical problem, if you are admitting a patient or you are giving a patient chemo, whatever.

Mr. ROSENDALE. Now, I am going to squeeze one more question in before the clock ticks down. Have you identified solutions for the patient movement prosthetics inventory and power plans problems?

Dr. BUCKLEY. Well, sir, we just had a big meeting this week where we bought in tons of subject matter experts that are attacking that problem. Again, a lot of the struggles with that movement comes across from DOD process versus VA process. VA has a much more exacting process to have accountability of prosthetics and implants and tissue management.

Mr. ROSENDALE. Okay. I have expired my time, so I am going to yield and recognize Ranking Member Cherfilus-McCormick.

Ms. CHERFILUS-MCCORMICK. Thank you. Dr. Evans, Oracle seems to be blaming the system collections failure on the Change Healthcare cyber incident. Millennium has struggled with expected to observe collections since the first go-live in 2020. Is that a fair assessment of the ongoing issue?

Dr. EVANS. A portion of the revenue cycle issues or delayed revenue collections has to do with the pharmacy copayments. Approximately 50 percent of the delayed collections are related to pharmacy copayments, which were not initially collected at the initial go-live sites because of some issues that needed to be sorted out with the system. That problem has been solved technically. The pharmacy copayments are being collected through FHCC and there have been no issues with that.

Ms. CHERFILUS-MCCORMICK. What has been the impact of the inability to collect the copayments and the third-party payments on the VA's budget?

Dr. EVANS. The impact on the VA's budget, so I think in many cases the impact is essentially a—you know, not that we will not be able to realize the revenue, but that the realization of the revenue has been delayed. I think Ms. Duke may have some thoughts on that.

Ms. DUKE. Yes. As part of the Change Healthcare we had a wider issue with delayed collections, so part of what we have been able to do is provide funds out to the medical centers based on expected collections against the anticipated carry over into 2025.

We are not identifying that as part of our shortfall because we fully expect that come 2025 we will be able to collect on these outstanding requirements.

Ms. CHERFILUS-MCCORMICK. For clarification, you are saying that the problems with copay and collecting third-party payments they are based off of the Change Healthcare incident? So——

Ms. DUKE. Other than the pharmacy issue that Dr. Evens mentioned, which was a known issue and, honestly, the delay has in restarting the collection has been to make sure that we communicate adequately with the affected veterans and make sure that they understand the bills that will be coming their way.

Ms. CHERFILUS-MCCORMICK. Millennium struggled to, has not been able to collect. What impact has Millennium had on it?

Ms. DUKE. The data that is coming available from that was not necessarily always in the form that we needed it to be, but I would say that we have always somewhat struggled with meeting our collections and we continue to work collaboratively with the EHRM office to ensure that we receive the data that is necessary for our collection staff to do their work.

Ms. CHERFILUS-MCCORMICK. Okay. Dr. Evans, we have been talking about concerns about copay collections for a while. I hear that the VA is now or is preparing to begin collecting. How far back are you collecting for sites that have not seen since their go-live?

Dr. EVANS. The initial collections will be from this point forward, so we will start to send out bills for this——

Ms. CHERFILUS-MCCORMICK. This point as far as today, is this point?

Dr. EVANS. When we restart pharmacy copayments, those pharmacy copayments will restart month to month with a statement for that month's charges. We, as a subsequent effort, will look to evaluate what the retrospective billing back to the original go-live would be and we will of course, be communicating with veterans about their—what options are available to them to ensure that they are able to manage those copayments or apply for waivers or whatever benefit might be available to them.

Ms. CHERFILUS-MCCORMICK. Would you be able to give me a range of how much money has not been collected from the copays and the third-party billers?

Dr. EVANS. I cannot give you that right now, but I can certainly take that for the record and be happy to brief your staff.

Ms. CHERFILUS-MCCORMICK. Wonderful. As I have a few seconds left, can I get your assurance that no veteran will experience financial hardship due to back collection of copays?

Dr. EVANS. Yes.

Ms. CHERFILUS-MCCORMICK. Thank you. I yield back.

Mr. ROSENDALE. Thank you very much, Ranking Member.

I now recognize Representative Self for another round of questioning.

Mr. SELF. Thank you, Chairman. Let us revisit some of the cost. We have—you said there were $16 billion, your initial estimate. We are some $10 billion into it now. You did not like my $50 billion, so why do not you tell me when we reached 2038 or whenever it is fully rolled out, what would your estimate be?

Dr. EVANS. I do not have an estimate I can provide you. As I mentioned, that would require us to have a schedule for what the further deployments are going to be.

Mr. SELF. Well, let us assume you roll out, when do you want to start?

Dr. EVANS. We have said that we will restart pre-deployment activities within Fiscal Year 2025.

Mr. SELF. Okay, so 25 to 38, do you have an estimate?

Dr. EVANS. I do not.

Mr. SELF. Okay. Dr. Buckley—and my question to you Dr. Evans is when are we going to see some Return on Investment (ROI), you know, in terms of any of those soft things you had either cheaper,

faster, better, whatever you want to quantify those, where do we see some ROI? Dr. Buckley, apparently you all hit 90 percent productivity back in April, but it led to burnout on your staff.

You are getting all of this extra personnel to help you, but then you just told the chairman that you do not need them going forward. What happens after they leave? Are you—what percentage are you going to be able to reach with the staff that you all have at that point?

Dr. BUCKLEY. Well, I think my comments—I want to clarify. I am not saying we do not need all of them. I am not saying we—you know, what number precisely at this point we are going to need, but we are going to—we are committed to make sure that we only bring on board those that we absolutely need. As we move forward in time we are starting to see—get a better estimate of that. There is a couple of important things.

Mr. SELF. Yes, sir, but let me make a point about that because this system has been described to me by one person as the – example would be—we used to have airplanes that took one pilot. We have got a higher technology plane now that takes two pilots.

I was going to use the analogy of I hope we are in the courting stage of this, of this relationship between VA and Cerner, but given the Chairman Bost comments we may be in the early marriage stage where we are too far committed and yet we have just lifted the veil and now we are seeing what we actually have. In either case I think we have got some work to do.

I want to address customization, Dr. Evans. Some people believe DOD did so well because they did not allow a great degree of customization. Between the VISNs, VA is allowing customization with no minimum standards.

Can you address that? If we allow customization for everything, one, it is going to be more expensive and, two, eventually it will not be interoperable or seamless.

Dr. EVANS. Yes. Absolutely. I would love to address this. I think this actually gets to your earlier question about what the value proposition is. One of the most significant value propositions of deploying the Federal EHR is, in fact, our ability to have a single instance of an electronic health record that allows us to deliver a single best practice standard of care delivery across the enterprise.

Mr. SELF. How does customization fit into that?

Dr. EVANS. It does not. I think one of the things that we saw that is a story that I think we should celebrate from a success perspective is that in many ways at FHCC we were able to deploy what is the standard, what is becoming the standard deployment.

I will give you an example. How you name clinic locations in the electronic health record, whether it is a primary care clinic, a rheumatology clinic, an orthopedics clinic, the location of that clinic, how that is rendered in the electronic health record needs to be standardized. Otherwise how do you find the location where you are going to order something?

Mr. SELF. What is this——

Dr. EVANS. We were 100 percent, 100 percent compliant with standards—with the standard, the new standard at FHCC, which is very different than the prior five sites. We are now going back to fix the prior five sites and to bring them into the standard.

Mr. SELF. Chairman, I yield back. Thank you.

Mr. ROSENDALE. Thank you very much, Representative Self.

Ms. Duke, we are going to start talking math. As of June, Dr. Buckley was waiting for the VHA central office, presumably that is you, to release additional funding so they can hire the rest of the 216 staff that they have determined that they need sometimes. Sometimes we are being told they do not need them, but they cannot function without them, so I would say that they need them then. Has that happened, and if not, when will it happen?

Ms. DUKE. I believe the funding has gone out. If it has not it will be by the end of the month.

Mr. ROSENDALE. Okay. Ms. Duke, several of the departments at James A. Lovell say that they need even more staff to keep their heads above water, particularly medical support assist and some pharmacists, which do not seem to be budgeted at all. Are you able to provide those resources?

Ms. DUKE. We would not provide those resources from the central office. We are communicating with our VISNs to make additional funding available, but that is part of the identified shortfall that we have been in communication with you about.

Mr. ROSENDALE. Ms. Duke, conservatively, James A. Lovell is on track for 7 percent staff increase so far to mitigate the Oracle Cerner system's impacts. The Spokane medical center had to increase their staff by over 20 percent.

If the system was rolled out across the whole Veterans Health Administration, based on the current payroll that would mean between $3.5 billion and $10 billion staffing costs which is reflected here on this chart. That is on top of all the cost to purchase and implement the system.

That is just my back of the envelope math. You need to know the amount down to the penny. That is what your obligation is. Have you done any study or estimate of those costs and have you budgeted for them?

Ms. DUKE. We have not done those costs at this time. We are working with the EHRM office on the out—as we come out of the pause to ensure that we align our future resource requests with the requirements.

Mr. ROSENDALE. Will you commit to doing a study of the financial impact of implementing the EHR throughout the rest of VHA before the system is installed at any more facilities?

Ms. DUKE. Will I commit to? I will commit to working with EHRM office on identifying the resource requirements and aligning our budget request accordingly.

Mr. ROSENDALE. Okay. We would really like to have those costs before we have conversations about rolling it out at other facilities.

Ms. Duke, you informed the committee last week that VHA expects a $12 billion budget shortfall next year. Secretary McDonough testified in April that he plans to resume the Oracle Cerner roll out next year. How can you possibly justify introducing this disastrous system into more hospitals and diverting staff and resources when you are already in a serious budget crisis?

Ms. DUKE. What I would say is that it is—I will identify the necessary resources to implement the delivery of care consistent with where my organization chooses to go. If we do move forward in

2025 we will look at the requirements and ensure that they are possible within the available resources that we have.

Mr. ROSENDALE. We are already running a $12 billion budget shortfall in VHA. I am trying to figure out where are those additional funds going to come from because we already have the additional staffing requirements that we have seen.

We see that on average you have got somewhere between 7 percent and a 20 percent increase in staffing. Where is this additional revenue going to come from?

Ms. DUKE. The identified shortfall that was communicated in part was in response so the recognition that we were not going to be able to achieve the lower staff level that the original budget estimate had included.

Mr. ROSENDALE. I understand that. It is a shortfall. It is a $12 billion shortfall. Okay. When you already have that I am trying to understand how we are going to address—the EHR has thrown VISN 20 into a permanent budget deficit and a VISN 12 representative at Lovell warned committee staff that they do not have the resources to support more than one medical center implementing the system over the course of the year. That is for the VISN. They do not have the resources to support more than one medical center.

How much will resume in the EHR rollout across VHA in 2025 and 2026, and how are you going to find the money to pay for it?

Ms. DUKE. Again, I think I would echo Dr. Evans that the identified cost will be contingent on the identified plan and that we would communicate our requirements in the 2026 budget according to our practice to make sure that we are adequately resourced for whatever the plan ends up being once we do come out of reset.

Mr. ROSENDALE. You are going to come back and ask for more money?

Dr. EVANS. I think the other thing I would add is that though we fully acknowledge the staffing increases that have been necessary at the sites to date, we anticipate and our aim as we get better at using the system, as we increasingly standardize as has been discussed is to get to a point where we do not require significant additional staff in order to implement the system.

Mr. ROSENDALE. I understand that that is your hope and I understand that is your goal, but it is not reflective in reality——

Dr. EVANS. Understood.

Mr. ROSENDALE [continuing]. Dr. Evans, Okay. With that I have expired my time. I am going to yield to Ranking Member Cherfilus-McCormick for 5 minutes of questioning.

Ms. CHERFILUS-MCCORMICK. Thank you, Mr. Chairman. I wanted to go back to talk about the pharmacy copay issues. Do I understand correctly that you are looking at billing back to 2020 at the Mann-Grandstaff?

Dr. EVANS. As I mentioned, we are going to restart from time forward. We anticipate and are looking forward to briefing your staff on considerations with regard to copayments into the—with regard to prior copayments and the approach to that.

Ms. CHERFILUS-MCCORMICK. That is a yes? You are going back, you are going to start billing from 2020. Is that correct?

Dr. EVANS. We are working on a plan with regard to how we will address prior to current day.

Ms. CHERFILUS-MCCORMICK. Okay. I think we need to have a bigger conversation about that plan.

Dr. EVANS. Of course.

Ms. CHERFILUS-MCCORMICK. Our concern is becoming that we do not know how it is going to impact our veterans going all the way back to 2020 without those copays, and if it might devastate them. Once you have a plan together we would like to talk more about that plan——

Dr. EVANS. Absolutely. We——

Ms. CHERFILUS-MCCORMICK [continuing]. to ensure that our veterans are not being devastated financially, if they are.

Dr. EVANS. We fully intend to speak to the staff and that is in part why we are not starting with anything that is retrospective or in arrears. We are looking only at the time going forward at this point in time.

Ms. CHERFILUS-MCCORMICK. Wonderful. I did want to go back to also the Change Healthcare situation. Is the current—is currently the VA's plan to reconnect with Change Healthcare or seek another vendor?

Dr. EVANS. I believe our plan is to reconnect with Change Healthcare, but, of course, we—as part of our commitment to moving forward.

Ms. CHERFILUS-MCCORMICK. What remains to be done to either reconnect with Change or another vendor to resume the collections? Well, I think it is going to be with Change, so what is required, what remains?

Ms. DUKE. My understanding is that we are working on the ability to reconnect to the clearinghouse and we had been identified that that would be completed by August of this year.

Ms. CHERFILUS-MCCORMICK. By August you expect that will be done?

Ms. DUKE. End of August, yes.

Ms. CHERFILUS-MCCORMICK. How confident are you that once Change Healthcare issues has been rectified, Oracle system will be fully capable of appropriate collections?

Ms. DUKE. Based on the data that we have seen so far, we are fairly confident.

Ms. CHERFILUS-MCCORMICK. Now, Dr. Evans, I have another questions for you. Actually, okay, what matrix do you plan to use to determine when it is time to restart go-live activities?

Dr. EVANS. The decision to restart pre-deployment activities—and again, I will remind you that that is just preparing a site for go-live. It is not an actual go live. There is a 15-month period of time between when we start that work and when we actually go-live will be a leadership decision that is driven by and informed by data.

We are evaluating four different categories of data to understand and help us make that decision. The first is the end user's experience, whether that be one of our staff or veterans. The second category is about our healthcare system operations.

We have talked today already about productivity, revenue collection, and other matters that are part of our health system operations. The third area is about the stability technically of the product, that is, that it is working reliably without outages or signifi-

cant hangs, crashes, or lags. Then the fourth area is looking at our program processes, how we are managing change, how we are delivering on our commitment to standardization through this project.

Ms. CHERFILUS-MCCORMICK. I believe you mentioned user satisfaction. What role does user satisfaction at the six live sites play in your decision-making and how do you measure use satisfaction?

Dr. EVANS. User satisfaction is critical. I think you are well aware that we have recommendations from U.S. Government Accountability Office (GAO) with regard to change management and user satisfaction that we are considering very carefully as we move forward.

As part of our commitment to better understanding user satisfaction, we have increased in the frequency by which we are surveying our users. We are using a standardized instrument that allows us to have comparability with private sector healthcare organizations as well as with the Department of Defense. That survey is being done more frequently, at the moment approximately twice a year.

Ms. CHERFILUS-MCCORMICK. I have a few seconds. I just wanted to know what is the threshold you must—you are looking at before achieving restart?

Dr. EVANS. I mean, I think what is critical for restarting pre-deployment activities is that we see trends moving with—and not just in a small way in a positive direction, but a positive, consistent trend with regard to user confidence and user satisfaction.

You know, again, we will continue our improvement efforts as we then are preparing to go live again. What we really want to know is are we moving in the right direction with regard to user satisfaction?

Ms. CHERFILUS-MCCORMICK. Thank you. I yield back.

Mr. SELF [Presiding]. Thank you and I recognize myself for 5 minutes.

Now, I want to get into the pharmacy. Okay. Before I do, I do understand, Dr. Evans, that we will see a request. I just want everybody that is watching to understand this. We will see a request for $12 billion to cover the shortfall in VHA?

Dr. EVANS. I will defer that to Ms. Duke.

Ms. DUKE. At this point we have communicated the need and I would defer to the Office of Management and Budget on the way in which any request would come over to the Congress.

Mr. SELF. Okay. All right. I want to move to the pharmacy here. Please do not filibuster any of these because we do have to—we have some issues to get through here. Obviously, Dr. Buckley, there are problems in your pharmacy and I think the pharmacy organization within the VA recommended you not go live.

Can you explain the new difficulties that you are having with the community living center and the mixing DOD and VA patients? Would you just quickly do that?

Dr. BUCKLEY. Sure. I do not really have a good response for you for community living centers precisely, so I would have to get some more specifics on your question. The joint—as I mentioned, the joint VA-DOD deployment involves two separate pharmacies, two separate benefits, and the need to at the window to understand when the patient comes to the window which benefit they are going

to use. We have struggled with that in the past and it is much—in many ways for the providers it is much better.

Mr. SELF. Okay. We have, I think, we have been over this, but just real quickly, how many worked in your pharmacy before Oracle Cerner went live, how many have you added, and how many more will you potentially need, three figures?

Dr. BUCKLEY. Yes, sir. Well, like I said, for precision I will take it for the record, but I am going to give you the figures. Before 140; currently, permanent staff, 132, down; additional NESSU support, 5. That puts us now for doctors and public, 139. We are still a little less than we started at baseline if you look at FTE. Now, I am not talking about there is overtime, there are other factors, I agree.

Mr. SELF. Okay. Your figures are different than mine, which are 140 FTE previously, you have added 24 FTE, and you are waiting approval for an additional 41 for a 46 percent increase. Those are the figures we have.

Dr. BUCKLEY. Yes, sir.

Mr. SELF. You are able to, with all of these additional FTE, you are able to produce about 40 percent of your normal workload. You are relying on National Supplemental Staff Unit to handle about 50 percent and then other pieces of the VA are pitching in for the additional—the remaining 10 percent. Is this acceptable, sustainable? How are you going to move forward?

Dr. BUCKLEY. I think it is necessary and I think the things that we are working on now to improve this EHR for the rest of the VA and for us is an investment that is well worth it and I think the additional FTE up to what we have asked for may be necessary. We are looking hard at that, like I said, every couple of weeks.

Mr. SELF. Okay. Dr. Evans, he needs something up to and including 46 percent increase FTE. How many pharmacists and technicians are available in your supplemental staffing unit for the whole of VHA?

Dr. EVANS. I do not actually know the specific number who are in the supplemental staffing unit to support pharmacy at the moment. The vast majority of resources from the National EHR supplemental staffing unit are able to be directed toward the facility in North Chicago. They being the most recent to have gone live. This is part of our projections as we plot our path forward to make sure that we are adequately resourced to supplement staff with regard to restarting with deployments.

Mr. SELF. It could be significant, though. Okay.

Dr. Buckley, you had a glitch on control substances. How are you mitigating that risk?

Dr. BUCKLEY. Well, that is another example where we have to have hypervigilance to the workflows. One of the big benefits to the Oracle product is they can track every single click that was ever made and if there is any nefarious activity with diversion, ultimately that is going to be detected.

Mr. SELF. I was in one of my hospitals just last week I think and they explained their system to me, a very sophisticated barcoding on everything, the drug, the patient, the distribution system. This can be done.

Ms. Verma, can you explain what the Pharmacy 3b/3c software update will do exactly?

Ms. VERMA. Yes, 3b/3c when implemented it kind of creates that closed loop system. If the pharmacist does not have exactly what the physician prescribed, then they can make modifications based on what is available and that change will be reflected back into the electronic health records so that the provider can see that change as well. That is what we are working toward.

Mr. SELF. Will that fix the problems that he has?

Ms. DUKE. It should fix some of them. I think whatever we kind of put in 3b/3c, it will address the problem that I just described.

Mr. SELF. Okay. Thank you. Ranking Member Cherfilus-McCormick.

Ms. CHERFILUS-MCCORMICK. Thank you. Ms. Verma, Oracle's written testimony to its improving usability of the system as a notable focus of the reset, what sort of efforts has Oracle undertaken to improve usability of Millennium at the VA?

Ms. VERMA. Sure. Well, that is something that we are very much focused on. The end user experience is top of mind. One of the things that we have learned from our interviews and our time at the five sites is that a lot of times when we talk to the end user sometimes they are not clear on how to use the system. One of the things that we have done, especially with the go-live, with FHCC was to increase the training. I think that was critical.

I think we also agree that there should be some more effort toward support and more ongoing training, that it is not just a one-time, when you are implementing.

The other things that we have done from a broad level is that this has been focus for Oracle generally to improve end user, especially the experience of providers. Most EHRs have kind of focused on, you know, a lot of clicks and reducing the number of clicks.

What Oracle is doing from a companywide perspective is implementing things like our clinical digital assistant which listens. It is ambient listening and it can listen to the doctor-patient interaction. It can even decipher between casual conversation and between many people in the room to actually produce the doctor's notes and also create orders as well.

We have committed to moving the DOD and the VA to the cloud and by that movement to the cloud will enable the VA to be able to use this type of technology. That is the kind of benefit that the end users will be able to realize over time when that is implemented and it kind of gives you an example of the benefit of doing a project like this because it allows the VA to leverage modern technology.

Ms. CHERFILUS-MCCORMICK. Now, how much improvement would you say VHA staff are noticing and that you have heard from them for the usability of the new EHR?

Ms. VERMA. I think that varies from site to site. There are some sites that have seen more improvements. We have heard from some sites where they say they are actually spending more time with patients and they have actually reduced the amount of time that they are interacting with the EHR.

For other sites it may vary and it kind of depends on, I think as Dr. Evans referenced, that we have the different VA sites doing different things and so they are ability to adapt and to apply the

new workflows and configurations can vary from site to site, and some of them may require more.

Ms. CHERFILUS-MCCORMICK. Dr. Evans, could you please answer that question?

Dr. EVANS. Could you restate the question?

Ms. CHERFILUS-MCCORMICK. How much improvement would you say VHA staff are noticing in the usability of the new EHR?

Dr. EVANS. I mean, I think the answer is they are seeing improvement, but not enough and not quickly enough, and we feel a shared sense of urgency to accelerating the improvement in the user experience. I mentioned in my opening statement some efforts that we are understanding that we are referring to as big rocks. These are, you know, we have implemented—I mentioned that we have implemented well over 1,000 changes into the system since the reset started. Many of those were simpler changes that addressed maybe several users' issues, but were not big sort of game changes with regard to the user experience.

Some of that requires us to revisit some decisions that we made early in the program. Some of it requires us to do some of the hard work of standardization that you have heard mentioned many times during this hearing already.

Together we are focused on these issues and we specifically chose them and validated them with the field because the field, our users said, these are the issues that we think would move the needle the most with regard to user experience.

Ms. CHERFILUS-MCCORMICK. Thank you, Dr. Evans.

I want to go back to Ms. Verma. Did I hear you correctly when you said that you were not concerned about the too many clicks complaint?

Ms. VERMA. No, we are concerned about it and so that is why we sort of moved to resolving that in a way it does not require any clicks at all. Right? If go to something like ambient listening, the doctor would not have to make any clicks at all.

We are very concerned about it. I think I would agree with Dr. Evans' assessment that the implementation of some of the big rock items, we will address that. Overall, we are moving to a system overall for Oracle that would not require physicians to do the data entry.

Ms. CHERFILUS-MCCORMICK. Thank you. Thank you. I have a few seconds. I just want to make sure I get this question to Dr. Buckley.

Several of the system's issues identified by your staff appear to be more related to providers not entering orders correctly or completely, which I suspect is related to the usability concerns.

Dr. BUCKLEY. Yes. You know, I think one of the things we have learned is that we need to work more on adoption and we need more multidisciplinary teams that come together to understand what is the precise way to order certain types of labs.

Ms. CHERFILUS-MCCORMICK. Well, we are over. I am over time.

Dr. BUCKLEY. Yes, ma'am.

Ms. CHERFILUS-MCCORMICK. I just want one more second to—okay. Thank you. So, proceed.

Dr. BUCKLEY. Yes, there is a need to retrain or reinforce with—certainly with the ordering providers, with the nurses that take the

orders and scan them, with the lab that receives the specimen, all of those need to come together.

That is part of healthcare operations. That is—it is really up to me. I am ultimately responsible to make sure that happens and to make sure we are using the workflows, right, and that we are establishing accountability to use those workflows.

Ms. CHERFILUS-MCCORMICK. What is your facility doing to improve the completion and accuracy of provider order entry and is this an issue with accountability?

Dr. BUCKLEY. Yes, for both. I think one of the things we are doing is partnering with Oracle, is they have good tools that they can identify where are those providers that are struggling most with lots of workflows, but let us say lab order entry specifically. They can identify who those providers are and provide additional user experience training for them.

The other thing that is an impact right now is it is July. Right? What happens in July is new interns, residents that do a lot of the ordering, rotate in, and they are learning the right thing to order, whether you were clicking it, writing it, typing it, they are learning it. Sometimes that takes an additional amount of reinforcement. The good news is this product actually shows where those—where that is happening and it is pretty accurate.

Ms. CHERFILUS-MCCORMICK. Thank you. I yield back.

Mr. SELF. Thank you, Ranking Member Cherfilus-McCormick.

I want to thank all of our witnesses for joining us today. I also want to encourage all of you to think about the consequences of the decisions you make. We often talk about inputs here, what you were doing to the system inputs. I encourage you to think about costs and outputs because that is what is important to the veterans. Not only in the short term, but the long term.

There are many careers and reputations wrapped up in this and it is too easy to sit in Washington and make up budgets and schedules, but, frankly, we have veterans out there that need results. We have got millions of veterans, hundreds of thousands of VA employees that need good decisions. The decisions you are making about EHRM may hobble you for decades to come with these figures that we were throwing around today. I urge you to put your immediate concerns aside and become responsible stewards of the organization.

I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and include extraneous material. Without objection, so ordered. This hearing is adjourned.

[Whereupon, at 5:57 p.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Neil Evans

Good afternoon, Chairman Rosendale, Ranking Member Cherfilus-McCormick, and distinguished Members of the Subcommittee. Thank you for the opportunity to testify today about VA's initiative to modernize its electronic health record (EHR) system. I am accompanied by Dr. Robert Buckley, Director of the Captain James A. Lovell Federal Health Care Center (FHCC) in North Chicago, Illinois and Ms. Laura Duke, Chief Financial Officer, Veterans Health Administration (VHA).

I want to begin by thanking Congress and this Committee for your shared commitment to Veterans and for your continued support of the Department of Veterans Affairs' (VA) EHRM efforts. VA remains committed to successfully implementing the Federal EHR across its enterprise. VA's implementation of the Federal EHR will provide a single, accurate, lifetime health record for Veterans that includes their health records from the Department of Defense (DoD). The new Federal EHR will provide a framework for improved enterprise standardization of health care delivery, which should, over time, positively impact patient care quality and safety. The Federal EHR will also support simpler integration of other modern health information technologies and infrastructure to provide a more coordinated experience for VA staff and clinicians as they care for Veterans. The modernized EHR will also support improved interoperability with the rest of the American health care system.

Additionally, the adoption of a single system used by both VA and DoD will help to simplify health care delivery for providers in both Departments, benefiting patients who receive care in both systems or who are transitioning from DoD to VA for care. It should also improve opportunities for collaboration and joint operations between the health care systems.

VA's focus is keeping Veterans at the center of everything we do. Veterans deserve high-quality health care, which means health care that is timely, safe, Veteran-centric, equitable, evidence-based, and efficient. The EHR is, and will remain, a key enabler of VA's ability to deliver the comprehensive health care Veterans deserve. VA remains committed to delivering an EHR that will support these goals.

Reset and Path to Restart

The EHRM Program Reset was announced on April 21, 2023, with goals of (a) addressing the concerns of the sites where the system was live, (b) investing in foundational enterprise work necessary for long-term success, and (c) preparing for successful deployment of the system at Lovell FHCC. A little less than a year later, VA, DoD, and the Federal Electronic Health Record Modernization Office (FEHRM) realized one of those goals by launching the Federal EHR at Lovell FHCC in North Chicago, Illinois, and at its affiliated clinical care sites, on March 9, 2024. Progress toward achieving the other two goals continues with notable accomplishments outlined in the following three sections.

Clinician and Veteran Experience

Over the past year, VA has continued to listen to and engage with Veterans and clinicians about their experience with the Federal EHR. One of the Reset's initial workstreams was focused on implementing rapid system improvements. This work effort resulted in 160 configuration changes that were part of a prioritized "punch list" of requested modifications to the EHR build—with a goal of quickly and responsibly improving the experience of end users at the live sites. Beyond the initial punch list, in total, more than 1,500 configuration changes have been implemented in the past year. Other improvement areas focused on addressing patient safety concerns. These included resolution of 6 patient-safety related new service requests and more than 100 patient safety recommendations from the February 2023 Sprint Report. One example of these changes was the increased visibility of Patient Record Flags that alert end users to a Veteran's potential risk for suicide, which now appear "center screen" for end users interacting with the system in furtherance of VA's goal of preventing Veteran suicide.

Outside of improving the EHR product itself, VA provided increased adoption support in the form of change management activities, training, ticket management, and transparent communications. With the March 2024 go-live at Lovell FHCC, VA implemented new change management activities, which were well received by end users, including (1) establishment of the Super-User Competency, Collaboration, and Enhanced Skills Support event designed to equip super-users and provider champions with the knowledge and skills to lend support to other end users; (2) the development of Learning Labs to allow end users to practice what they learned in a simulation environment, and which led to more than 90 percent of post-event survey respondents reporting improvement in their readiness for go-live; and (3) improved sustainment support, such as onsite support during and after go-live, learning opportunities for peers to share tips and tricks, enhanced communication with end users, and the Sustainment Resource Center, a website containing useful reference materials.

Another key Reset effort aimed at improving the clinician experience has been the informatics workforce development workstream, which works to develop independent EHR competencies and expertise for informaticists in VA to allow for increased self-sufficiency in managing EHR configurations and adoption efforts nationally. To date, 59 informaticists and 24 solution experts have completed foundational and intermediate training associated with these efforts.

Clinician experience was also improved through more responsive ticket management, including identifying the most pressing concerns through ticket analysis, rounding, and informatics staff feedback. These activities resolved many systemic problems. From July 2023 through May 2024, VA resolved 1,293 aging incident tickets (reduced aging open incident ticket backlog by 60 percent) and resolved the vast majority of its backlog of provisioning new employees with user accounts, ensuring providers have the system access they need to perform their duties. The ticket submission experience was further improved by deploying the EHRM Pathfinder within VA's ticketing system, which allows for self-service, guiding end users through a series of questions to log their problems more appropriately and efficiently. Additionally, VA redirected tier 1 help calls to the VA Enterprise Service Desk to expedite the turnaround time for ticket resolution, preventing approximately 40 percent of incident tickets from going to Oracle Health when they could instead be resolved more expediently by VA directly.

High Performance and Reliability of the System

As a result of VA's systematic approach over the last year, we have seen the core Federal EHR increasingly stabilize over time, resulting in improvements to the user experience. In the last 16 months, through May 2024, Oracle Health incurred 377 outage minutes, slightly more than 6 hours. By comparison, the total outage minutes in the 12 months leading up to the Reset announcement in April 2023 were 1430. The incident-free time (IFT) rate also improved, though remains an area of significant attention. Since June 2023, the IFT Service Level Agreement (SLA) has been a contractual requirement, and the SLA of greater than 95 percent was achieved in 8 of the 12 months, compared to 2 of the 12 months leading up to the Reset announcement. Oracle Health also achieved a 30 percent reduction in hangs and crashes experienced by the 1 percent of system users experiencing the worst performance among their peers.

One of the Reset's workstreams focused on a technical "get well" approach. Through focus group feedback, the team was able to better understand end user pain points with the system and thus resolve their issues. For example, the team resolved device slowness by automating Virtual Private Network (VPN) selection and fixed configuration issues related to incorrect telehealth date/time pop-ups and alerts. A visit to the Mann-Grandstaff VA Medical Center (VAMC) identified similar performance issues (such as VPN use while at the facility), and issues were corrected in real time onsite.

From a system performance perspective, one of the advantages of the Reset has been the time it has provided for optimization of the system and associated technical processes. For example, significant attention has been paid to ensuring adequate testing and rigor for all system changes and completion of comprehensive root cause analyses for system incidents to improve overall performance. In addition, VA anticipates that system performance will continue to improve as the change velocity decreases and enough time has passed to enable unanticipated defects to be addressed.

Improved Productivity at the Sites (Operations)

EHRs, including their associated specialty applications (such as laboratory, pharmacy, medical devices, and other prosthetic and sensory aids, radiology, blood bank),

are a critical enabler of health care operations. Effective configuration and adoption of these systems are important for assuring full productivity of clinical and administrative staff, restoring and improving revenue streams, and enabling effective administration of health care operations.

VA has pursued numerous interventions to measure operational impact and to improve it. System enhancements, staff adoption interventions, and operational management interventions all contribute to this necessary improvement. In support of improved operations, EHRM completed several releases of EHR upgrades over the past year. These upgrades enhance existing capabilities and interfaces and ensure platforms remain current on software code.

Most recently, the February 2024 Block 10 release included capabilities to allow ordering clinicians to request prescription refills more easily for the Veterans they serve and enhancements of address verification when pharmacy staff process mail prescriptions. As of the Block 10 release, all but one of the original seven priority pharmacy enhancements have been delivered and deployed.

Block 10 also introduced the newest versions of the Millennium, MPages, Clairvia, and Rhapsody software that will allow the Federal EHR to scale solutions for increased user capacity, improve stability, and lay the groundwork for future capabilities. These software upgrades also included corrections for numerous defects, incrementally improving productivity and user experience. Block 10 also deployed additional changes to reduce user interruptions, resulting in an 11 percent improvement across all sites, a 42 percent improvement at the Jonathan M. Wainwright Memorial VAMC, and a 30 percent improvement for ambulatory nurse roles. Evidence of progress has been demonstrated in the user surveys administered before and after each code block release—compared to the Block 9 surveys, the pre-Block 10 survey had a 138 percent increase in respondents and showed user satisfaction improving from predominantly very dissatisfied to predominantly neutral. In addition to the configuration changes that are delivered every week, Block 11 will be the next major release of new capabilities and is scheduled for August 2024.

Addressing the "Big Rocks"

While our current progress is reassuring, there is still important work ahead. VA clinicians and staff continue to experience challenges with some aspects of the Federal EHR. Several of the improvements that end users have requested, and other improvements that we know are important for long-term success, require re-visiting decisions made early in the program now through the lens of lessons learned by DoD, VA, and best practices of other Oracle Health customers. These projects are more significant than a simple fix, requiring significant collaboration across multiple stakeholders and coordinated decision-making. These are being referred to as "big rocks" given our prioritization of these efforts as part of our ongoing improvement endeavors (cf. *First Things First by Stephen Covey*) and because of the scope of the tasks.

These Big Rock items were validated by the feedback that VA Deputy Secretary Tanya J. Bradsher and I received when we visited the initial five live sites the week of April 29. Users stressed that improvements in specific key areas would make their system experience significantly better. During the week of June 10, VA leaders hosted a face-to-face meeting bringing together subject matter experts and representatives from the live sites currently using the Federal EHR to scope and develop work plans on several of the Big Rocks.

As examples, some of the targeted Big Rocks efforts improvements are: (1) re-visiting the approach to referral management in the Federal EHR to standardize and decrease the amount of medical documentation required for entering referrals; (2) improving training content and delivery for new users so they are better prepared to perform their job in the Federal EHR; (3) standardizing and, when possible, consolidating over 300 different user roles or positions in the system to relieve individual users from having to log in and out to perform different position-specific functions; (4) Message Center optimization to assist staff in managing communication internally and externally; (5) improving PowerForms by standardizing how the capability is designed and used across clinical areas; and (6) delivering the Pharmacy 3b/3c feature, intended to improve the automated coordination of prescription information between ordering clinicians and the pharmacy team.

In parallel to the Big Rocks effort, the existing Reset workstreams continue in the latest increment, which runs through August 31, with their focus on process improvements that will support the Big Rock efforts, increase the pace of change, and move the program toward restarting deployments. Some examples of these Reset workstreams efforts include operationalizing an effective and transparent configuration process that resolves end user requests in a timely and transparent manner; conducting site visits to observe and listen to our end users, with one-on-one tech-

nical troubleshooting focused on users with the worst experiences; and using that end user feedback to evaluate workflows and determine where deviations from the intended model are creating challenges.

Assessing Readiness to Restart

Although it is still too early to discuss concrete plans for resuming deployments, VA remains committed to exiting Reset and successfully implementing a single enterprise-level health record that works more effectively toward meeting the needs of VA. As Secretary McDonough has stated in recent budget hearings, VA anticipates exiting Reset and restarting pre-deployment activities in Fiscal Year (FY) 2025. To this end, VA has developed a dashboard focused on providing VA leadership and stakeholders with metrics and thresholds that are clear, measurable, and actionable to support a data-driven decision regarding restarting deployment activities. Of note, the dashboard metrics are just one point of reference that will be used by leadership as restart decisions are made. Also, it is anticipated that many of the items on the dashboard will be useful to continue to track, well after the program Reset has concluded.

This dashboard establishes objectives and key results within the following four areas:

(1) Improved user and Veteran experience (how the Federal EHR system is experienced while performing daily work, by VA users and Veterans);
(2) Improved health system operations (how effectively the EHR is supporting VA's business and clinical operations);
(3) Mature product (how well the technical solutions themselves are functioning and how that is affecting the user and health system experience); and
(4) Mature program processes (how the Department, and other Federal partners, are able to coordinate support and continuous improvement of the Federal EHR).

Those associated with this effort across VA feel a sense of urgency to complete the work of the Reset, continue optimizing the Federal EHR system for current users, and move to restart deployments across the rest of the enterprise. While we have not determined an exit date for Reset, we are closely monitoring the dashboard, our execution of the Big Rocks, and progress from our Reset workstreams over the coming months.

When the Reset concludes, VA will release a planned deployment schedule for the initial 2 years post Restart and will resume deployment activities with greater confidence in the readiness of both the Federal EHR system and the VA health care system to successfully navigate this important change.

Lovell FHCC Deployment

As VA has said previously, ensuring a safe and successful deployment, followed by support for the ongoing operations of the Federal EHR post go-live at Lovell FHCC has been a top priority of the EHRM Program Reset. The Federal EHR was successfully deployed at Lovell FHCC on March 9, 2024. Throughout the initial go-live period, in addition to contracted adoption support, traveling DoD super users from the "Pay it Forward" program and VA Super Users from the National EHRM Supplemental Staffing Unit worked daily with VA and DoD end users, enhancing the effectiveness of the go-live. Regular huddles at the site level and at the national level to identify, triage, and accelerate addressing identified issues have also been helpful.

VA, DoD, and the FEHRM continue to support and closely watch progress at Lovell FHCC. The initial success of the Lovell FHCC deployment was built on lessons learned across DoD and the five previous VA deployments, as well as improvements accomplished during VA's Reset efforts to date.

As a result of some of the aforementioned Reset efforts, additional informaticists were available to assist with the Lovell FHCC deployment effort, including supporting submission of help desk tickets. Through the work of the Informatics workforce development workstream, staff at Lovell FHCC received supplemental training on high-risk topics to provide the necessary VA-context to the Oracle Health systems training and reported that the training made them feel more comfortable, safe, and prepared to perform their work with patients.

At this point, it is still too early to declare final and unequivocal success. However, the results at Lovell FHCC have been promising and there have been no critical patient safety incidents reported as of the date of this hearing. Lovell FHCC has maintained 100 percent capacity for the emergency room and inpatient bed cen-

sus for mental health throughout deployment, and inpatient bed census capacity for acute medical and Intensive Care Unit care has returned to baseline from a 50 percent reduction at go-live. Outpatient productivity is up to 70 percent from a 50 percent reduction for go-live preparation. The site expects this number to continue to rise as more appointments are opened every week. While some challenges remain, this is to be expected from any new EHR deployment. Lovell FHCC staff continue to watch closely for patient safety issues and report them as they arise in alignment with VA's culture of high reliability, and the team remains committed to meeting Lovell FHCC's care and readiness mission.

Contract with Oracle Health

On June 13, VA announced the award of the second option period for its contract with Oracle Health, with an emphasis on improved fiscal and performance accountability. The 11-month option period award demonstrates VA's commitment to—and sense of urgency for—emerging from Reset and resuming deployments at scale. This contract will also support potential pre-deployment and deployment activities at new sites in Fiscal Year 2025 once restart is commenced.

During negotiations for this second option period, we focused on two main objectives: (1) supporting value-added services, such as system improvements and optimizations; and (2) achieving better predictability in hosting, deployment, and sustainment costs. Last year's negotiations modified the contract to dramatically increase VA's ability to hold Oracle Health accountable across a variety of key areas, including minimizing outages and incidents, quickly and reliably resolving clinician requests, interoperability with other health care systems, and interoperability with other applications so that Veterans have a seamless and integrated health care experience.

These efforts of the past 2 years will help us maintain fiscal responsibility in the best interest of Veterans, VA providers, and taxpayers alike. Executing the second option period of the contract allows VA and Oracle Health to continue to drive forward, navigating the path to restart and then proceeding with deployments at scale with an EHR that effectively supports our Veterans and clinicians. VA remains committed to holding ourselves and our vendors accountable for resolving challenges with deployment of the Federal EHR and moving forward productively.

As we further define success, we will identify and communicate the strategy for the path to restart and the initial deployment schedule as noted above.

Other Program Improvement Efforts

As of June 18, 53 of the 82 recommendations from VA's Office of Inspector General (OIG) have been closed and 29 remain open. There are two OIG recommendations that are older than 3 years; these and several other recommendations may be put on pause for the duration of the Reset since the OIG recommendations can only be demonstrated/closed through deployments once VA exits the Reset. The EHRM Integration Office continues to work closely with its partner offices to expeditiously adjudicate the outstanding recommendations. As of June 15, 2 of the 15 GAO recommendations are closed. Thirteen recommendations remain open for program monitoring—of those, three reports will continue to remain open for program monitoring and reporting (e.g., ongoing ticketing reports/testing reports, workshop details, change management).

Budget and Cost Update

As part of the Reset, VA is committed to continuing to work with Congress on resource requirements. The Fiscal Year 2025 Budget request of $894 million funds optimization and sustainment of the 6 live sites, infrastructure readiness, and retention of the current level of staff support to sustain momentum throughout the Reset period. With prior year funding carryover, the budget request will allow VA to restart pre-deployment activities when we are confident the necessary improvements have been made at our current sites and that the Federal EHR is ready to deliver for Veterans and VA clinicians at future sites.

Conclusion

We know from listening to both Veterans and VA clinicians that the Federal EHR is not yet meeting expectations—and we are holding Oracle Health and ourselves accountable to get this right. While our current progress in the program Reset is reassuring, we still have important work ahead. We expect to see continued improvements at our current sites, including key areas related to the Veteran and staff experience, technical performance, program processes, and impacts on facility operations. We will be tracking these measures closely.

VA is continuing to move forward with a modern, commercial EHR solution in close coordination with our Federal partners, including DoD and FEHRM. This new Federal EHR system will allow VA to standardize workflows, training, and technology management across VA using a single enterprise system and will support better coordination with DoD, other Federal partners, and private health providers.

Veterans remain the center of everything we do. They deserve high-quality health care that is safe, timely, Veteran-centric, equitable, evidence-based, and efficient. They also deserve access to high-quality clinical trials. As improvements continue to be made through the duration of this Reset, VA will continually evaluate the readiness of sites and the Federal EHR system to ensure success and patient safety. With the activities and improvements that are now underway, VA leaders are optimistic about the eventual success of the current Reset and subsequent full implementation of the Federal EHR throughout VA.

I again extend my gratitude to Congress for your commitment to serving Veterans with excellence. This concludes our testimony. We look forward to responding to any questions that you may have.

Prepared Statement of Seema Verma

ORACLE
Health

Statement of the Honorable Seema Verma, Executive Vice President and General Manager, Oracle Health and Life Sciences, Oracle Corporation

Before the

U.S. House
Committee on Veterans' Affairs
Subcommittee on Technology Modernization

Hearing on:
"Report Card: Assessing Electronic Health Record Modernization at the Captain James A. Lovell Federal Health Care Center"

July 22, 2024

Introduction

Chairman Rosendale, Ranking Member Cherfilus-McCormick, and members of the Subcommittee, thank you for the opportunity to speak with you today about Oracle's work with the Department of Veterans Affairs' (VA) Electronic Health Record Modernization (EHRM) program.

I am Seema Verma, Executive Vice President and General Manager for Oracle Health and Life Sciences. I am a former Administrator of the Centers for Medicare and Medicaid Services and have focused on healthcare throughout my career. At Oracle, I am responsible for the company's healthcare business, including Oracle's work to modernize the Electronic Health Record (EHR) for VA and other federal customers such as the Department of Defense (DoD), Coast Guard, National Oceanic and Atmospheric Administration (NOAA), and the Indian Health Service (IHS).

Oracle has served as a technology partner for the federal government since our founding in 1977. Though we operate globally and in fact maintain the largest global EHR market share, we are an American company. We take our work for the United States government very seriously and feel privileged to contribute to our veterans' health along with supporting defense, intelligence and other critical departments and agencies.

The work of modernizing healthcare technology for VA, DoD and other federal partners is a key mission of the company, and we are devoting substantial engineering, healthcare expertise, and other resources to this specific project that is intended to improve the VA provider experience as well improve the delivery, efficiency and outcomes of the care provided by the VA.

We continue to strongly support the VA EHRM program's mission to ensure that service members have a single, lifelong health record from their first day of service through their lifetime care at VA. The modern EHR we are delivering to VA, DoD, the Coast Guard, NOAA, and IHS eliminates the need for patients to rely on memory or outdated, sometimes missing or incomplete paper records. With an interoperable health record, patients receiving care at a VA clinic one day and a community care site the next will have their full health history accessible to both sets of providers. This seamless access to comprehensive health records significantly improves the quality of care for our veterans.

In the two years since Oracle acquired Cerner and took over its obligations for the EHRM program, we have made significant improvements to the technical performance of the system, worked with VA to standardize and simplify EHR workflows, enhanced training, worked with currently live sites to improve productivity and revenue collections, and sped delivery of critical pharmacy enhancements, among other important updates described later.

Our work has paid dividends, as seen with the successful deployment in March 2024 at the Captain James A. Lovell Federal Health Care Center (FHCC) in North Chicago. There is still work to do of course, and our progress continues at a strong pace. However, we believe the successes we have seen recently with the Lovell FHCC deployment and the changes and updates made through the course of the current "reset" have positioned the program to exit the reset and resume pre-deployment activity this year and go-lives next year.

We made several recommendations to VA through the course of the reset, including for how they can: (1) institute stronger governance controls through clearer escalation paths for program decisions, such as those requiring cross-council consensus; (2) enhance change control processes through closed loop communications with end users and enforcement to standards; (3) standardize workflows and healthcare protocols, such as referral management, workload capture, and mammography; (4) improve system performance and operations; (5) optimize end user engagement and communications; and (6) advance workflow adoption and optimization.

Akin to our recommendations, VA has stood up ten workstreams during the reset period and has most recently onboarded several "big rock" projects, which are specific initiatives aimed at improving the user experience, efficiency, and outcomes. VA's efforts towards standardization, establishing an effective configuration process, and creating playbooks to ensure alignment to model workflows will help VA create one standard of care across its healthcare enterprise and enable VA to provide quicker answers when deviations from the standard EHR are requested. Further, several of VA's "big rock" projects, such as position standardization (i.e., ensuring every healthcare worker with the same job title and responsibilities uses the EHR system in the same way), referral management, and ad hoc folders (i.e., organizing documentation that captures patient information in a standardized way), demonstrate a commitment to achieving standardization across the VA healthcare system.

Lovell FHCC

Four months after the deployment of the new EHR at Lovell FHCC, the system has been well-received by users, enabling them to provide excellent care to veterans, active-duty military, and their dependents. Compared to the original five live sites, improvements in change management, training, and communications have led to notably higher adoption rates at Lovell FHCC during this phase of implementation. Moreover, the new EHR delivered substantial advancements over the legacy system at Lovell FHCC, particularly in areas such as interoperability, productivity, and patient safety.

Adoption - Users are demonstrating faster adoption and lower time spent in the EHR than at previously live sites. For example, providers are averaging less than 28 minutes in the EHR, and nurses just under 9 minutes per patient seen.

Productivity - In the Emergency Department, average weekly patient volumes have increased by 14.5 percent over pre-deployment averages, with total length of stay averages decreasing by 7 minutes. Instead of needing to use 5 or 6 different logins, Emergency Department providers now have everything they need to care for a patient in one system, the new EHR.

Ambulatory patient volumes range from 70 to 90 percent of pre-deployment levels, depending on the Patient Care Location (PCL) and the site is working to increase the volumes by 10 percent each month, which is faster than the other sites. This volume and increase is consistent with other complex facilities four months after a go-live.

As Lovell FHCC strives to ramp up all department volumes to 100 percent by this October, Oracle will continue to provide in-person, on-site support for users and work with Lovell FHCC on specific areas where their workflows will need to be modified to adapt to the new standard provided in the EHR. For example, last week we began rapid process improvement work with the Prosthetics and Sensory Aids Department to help them adapt to a significant change in the number of orders to be considered in their workflow.

We undertook a similar effort in April to assist with lab ordering and specimen collections, which alleviated confusion between the providers, nurses, and lab techs over their roles, streamlined the workflows, and ultimately resulted in a higher percentage of correct inpatient lab orders.

Patient Safety - The new EHR has enhanced patient safety measures compared to the legacy system at Lovell FHCC. Key improvements include the implementation of medication safety protocols and closed-loop medication documentation, which ensure accurate medication administration. The implementation of bedside barcode scanning has enhanced verification processes by allowing clinicians to confirm patient identities and medication accuracy at the point of care, thereby reducing the risk of errors. Furthermore, the full deployment of automated medication dispensing cabinets streamlines medication management, providing secure and efficient access to medications while minimizing the potential for dispensing mistakes. Together, these advancements create a safer environment for patient care and improve overall treatment outcomes.

Pharmacy - The Lovell FHCC pharmacy is dispensing prescriptions with similar volumes and window wait times as prior to the deployment. We recognize that pharmacy staffing has increased post-deployment to maintain that same level of throughput. However, enhanced training also contributed to the throughput levels and successful implementation, specifically, weeklong sessions were conducted in November 2023 with the entire pharmacy operations staff, working through various situations and workflows. In addition, knowledge transfer series led by pharmacists were held. Overall, Lovell FHCC pharmacy staff provided a 9.82 out of 10 rating for the workflow adoption training sessions they received.

As with the other live sites, Lovell FHCC benefits from pharmacy safety features inherent in the Oracle pharmacy module, known as Medication Manager Retail (MMR), that are not present in VistA:

1. In MMR, pharmacists can view VA and community care prescriptions together, in a single provider view.
2. Pharmacists can see relevant clinical information and lab values within the pharmacy application during prescription processing. This capability informs proper prescription dosing without leaving the order to go to another screen, unlike VistA.
3. The new EHR allows for improved communication between VA pharmacists and Consolidated Mail Outpatient Pharmacy (CMOP) pharmacists checking prescriptions. VistA does not have this capability which can lead to prescriptions being sent back to the local VAMC for clarification. This feature has been used nearly 9,800 times in fiscal year 2024, which saves time in the fulfillment of prescriptions because it reduces the chances of the CMOP canceling a prescription back to the local VA facility.
4. The new EHR allows VA pharmacists to communicate electronically with community care providers when requesting prescription renewals. This is another net new capability, and it has been used by VA pharmacists more than 5,400 times in fiscal year 2024. This represents 5,400 phone calls not made to community care providers by VA pharmacists. This enhances continuity of veteran care with prescription medications and encourages prescriptions staying inside of VA even when authored via community care.
5. The new EHR also includes enhanced decision support, including dose range checking alerts and the Opioid Advisor Tool. The Opioid Advisor Tool allows clinicians to simultaneously check data from 47 state Prescription Drug Monitoring Programs (PDMP) and DoD facilities to prevent improper prescribing of controlled substances. Previously clinicians had to leave a patient's record and access PDMP data through each state's website with different passwords for each site. The Opioid Advisor tool has guided more than 3,500 modifications to opioid prescriptions since Oct. 2020. In these instances, the provider made a different and beneficial clinical decision based on the information the system provides. This information includes previous overdose attempts and any history of suicidal ideation. This is a net new capability that supports safer care of veterans.

Training and Change Management - Oracle believes that a significant factor in the success of the Lovell FHCC deployment was the addition of new end user adoption activities (e.g., Departmental Workflow Readiness sessions and Learning Labs). These activities reinforced formal training and provided participants with an opportunity to practice their workflows through simulated scenarios in the VA Sandbox.

Learning Labs were created to bring together end users, with support from super users (who are highly experienced users), provider champions and informaticists to develop a comprehensive understanding of selected respective service line workflows as a cohesive care

team. They were first piloted at Lovell FHCC in December 2023 for a small group of 54 super users. Post event survey data showed that more than ninety percent (92.1%) of respondents reported at least moderate improvement in their preparation for go-live, with nearly two thirds (65.8%) reporting great or exceptional improvement.

Based on the overwhelmingly positive feedback, the site and VA asked to partner with Oracle to expand the use of Learning Labs for end users prior to go-live. In close partnership with VA, we quickly stood up an additional 55 sessions for more than 200 end users. Because of the feedback from end users at Lovell FHCC, Learning Labs will be a key activity to help future sites prepare to adopt the new system.

In addition to the new end user adoption activities for Lovell FHCC, Oracle also made 36 early-access computer-based training programs available to super users to support their work and provided supplementary surge training to dual hat users, pharmacists, and pharmacy technicians just before go-live. Additionally, more than 70 supplemental training materials were provided to end users prior to go-live to reinforce important training topics.

Lovell FHCC is the first deployment that has taken place since Oracle's acquisition of Cerner. We strongly believe that the cumulative effect of the various improvements to technical performance, workflows, training, and support, and more undertaken the last two years have enabled this deployment to be successful and provide encouragement that VA can similarly and successfully deploy the new EHR to additional facilities with confidence.

Revenue Collections at Lovell FHCC and Other Live Sites:
Across all live sites revenue collections activity has been mixed and uniquely challenged in Fiscal Year 2024 due to the Change Healthcare cyber-attack. At the start of Calendar Year 2024, the five live sites had seen improved performance with collections to target reaching 100 percent of target from January to March 2024.

Occurring on February 20, 2024, the Change Healthcare cyber-attack stopped all billing processes involving third party claims for VA and all commercial clients. This meant that not only were collections stopped for all other health insurance (OHI) claims but also that the Medicare pass through process could not be facilitated. Until VA determines an appropriate path forward to establish a reconnection with Optum/Change Healthcare, or another intermediary, account balances will continue to be held from processing, and revenue collections will be limited. Once the connection with Optum is re-established by VA, Oracle stands ready to support all necessary activity to begin safely and efficiently processing claims.

Specific to Lovell FHCC, a financial scorecard is difficult to provide given the Change Healthcare cyber-attack. All claims processing at the site was down prior to the go-live and has continued to be so to present. As processing capabilities are re-established, Oracle is confident financial performance will improve and demonstrate desired outcomes to target.

Existing Five Sites

Improved Technical Performance

Major incidents that impact the availability of the EHR, such as outages, are tracked under our contract by an Outage Free Time (OFT) requirement. Since August of 2022, just 2 months after the acquisition of Cerner, Oracle has met or exceeded 99.95 percent system availability every month except for April 2023, and March and April 2024. The 99.95 percent OFT threshold was set as the contractual Service Level Agreement (SLA) in June 2023 as part of the first contract extension. In March and April 2024, OFT was at 99.881 percent and 99.931 percent, respectively, because of two database bugs, one that has been completely resolved and the other mitigated with a final resolution coming in September.

Instances of degradations in service for the EHR, but not a full outage, are tracked in Incident Free Time (IFT). IFT continues to trend in the right direction as well. Since July 2023, Oracle-owned IFT has met or exceeded the contractual requirement of 95 percent for eight of the past twelve months, including the last four consecutive months.

A user interruption is most frequently experienced when the EHR freezes, crashes, or hangs for a period of more than five seconds. Our contract requires that P50 user interruptions must average five or fewer daily (meaning 50 out of 100 users experience five or fewer daily interruptions). P90 user interruptions (90 out of 100 users) must average ten or fewer, and P99 user interruptions (99 out of 100 users) must average fifty or fewer.

Since January 2023, we have met the P50, P90 and P99 requirements every month, and the current average for P99 user interruptions is 24.94 versus the SLA requirement of no more than 50. This means that 0.45 percent of end users experience an interruption that lasts longer than five seconds. We continue to strive to reduce user interruptions with thirty-five updates going into the Code Block 11 update that will occur in August.

Each project within these themes contributes to a more stable system and enhances performance. For instance, we have improved our testing processes and test plan reviews, allowing more stakeholders to review testing plans and provide feedback. This review process ensures that the correct levels of testing, including regression testing, are performed for each change. Another project we completed was automating certificate rotation on non-Windows technologies. By automating this process, we reduce human error and the volume of incidents related to certificate expiration.

VA EHRM Reset

We are now just over one year into the reset and significant progress has been made. A notable focus of the reset is improving usability of the system, and as part of reset initiatives

Oracle has made approximately 1,500 configuration changes and 88 workflow updates to incorporate the voice of the frontline and simplify end user experience. More importantly, we are confident that the commitment to standardization and the newly developed Effective Configuration Process, introduced in the latest reset increment, will significantly enhance the consistency in care delivery across VA venues of care.

Reset Results Dashboard - An EHRM Focus Metrics Dashboard (Reset Results Dashboard) has been developed, in collaboration with VA, with nine focus metrics to inform the exit from reset. All nine metrics have been trending towards improvements except percent of total collections to expected results. We anticipate the percent of total collections to expected results to trend upward upon resolution of the Change Healthcare connection and the release of the Lifetime Pharmacy Encounter (LPE) statements that have been previously withheld by VA.

While the dashboard has been established, we continue to work with VA to firmly define the criteria for exit and to begin planning for future deployments.

Reset "Big Rocks" - While efforts to stabilize the system and improve functionality were underway during the reset, both Oracle and VA leadership visited the five sites to understand specific suggestions from end users to enhance the system. Many of the issues identified can be addressed with additional training.

In June 2024 Oracle collaborated with VA during five planning sessions to define thirteen so-called "Big Rock" projects that are not tied to the reset but that will help improve the user experience. These projects were selected by VA and range from the Pharmacy 3b/3c work to improving PowerForms and Quick Orders to standardization work and creating a new deployment schedule. Many of these projects will address some of VA's unique needs.

More than half of these projects are well in progress. For the others, Oracle's expectation is to hold follow-up workshops with our product engineering teams on these items to drive further definition and validation for a going-forward work plan.

We are enthused that the Big Rocks work plan will address issues of high user concern and make a significant difference in operations for the currently live sites as well as improve adoption at future sites.

Training, Adoption and Support Services

In the last two years, Oracle has worked with VA to improve the training program for new users as well as provide continued training for existing users on the overall system and updates to it. With better trained users, tickets and the need for support services generally decrease.

We have seen that at Lovell FHCC, new training programs such as the use of Learning Labs and increased utilization of super users paid off. Our focus on end users continues not just at Lovell FHCC, but at all the live sites. In the last six months we have held over 2,400 training classes for end users at the live sites.

At the live sites, we have conducted various onsite education and optimization activities to help end users adopt existing workflows and identify and execute configuration and workflow improvement opportunities. In addition to observing how end users interact with the new EHR and resolving their high-priority issues, we proactively identify end users with poor performance experiences and collaborate with VA to resolve these issues, including issues that are the responsibility of VA. Specifically, we have conducted training for Oncology and Long Acting Injections at VISN 20 sites to improve end user workflow adoption and experience.

At White City and Mann-Grandstaff, we worked with VA to identify and implement optimization opportunities and educate users on workflows for Optometry. At Jonathan M. Wainwright and Columbus, we executed similar projects for Audiology.

Oracle also utilizes workflow data to identify end users needing additional training. Once identified, we send our staff onsite to partner with the end users, assisting them in streamlining their workflows, thereby reducing time spent in veteran charts and increasing the time available to spend with veterans.

The enhanced training has had an impact on the number of tickets, and since VA entered reset, Oracle has exceeded the contractual SLA turnaround times for tickets with faster response times. In addition, Oracle has closed 24,000 tickets during this period and has decreased the active backlog by 17 percent in the last six months. We consistently close greater than 60 percent of our tickets on the first call and greater than 70 percent of our tickets in 24 hours.

For provisioning tickets to give end users access to the system or to specific roles, we have worked with VA to improve processes. We have seen an 18 percent increase in achieving the VA set target date for these requests, and last month we successfully met the VA's target dates on 98 percent of the provisioning tickets logged. Performance improvements have been achieved with the transition to the Microsoft Edge platform, resulting in a 51 percent reduction in full-page load time for Community Care Coordination workflows.

Pharmacy and 3b/3c Update:
Pharmacy 3b/3c is an update that will enable VA pharmacists to modify a prescription and have those edits return to the provider-facing application in the EHR. Those edits will then flow through subsequent renewals of the particular prescription. This requirement is unique to VA.

In February an update for 3b/3c was delivered to VA but the functionality was not turned-on because of VA's desire to modify the base design. In May, a two-day meeting was held with VA in which its final requirements were decided and agreed upon. Code development continues to be underway, with the expectation the 3b/3c update will deploy with the February 2025 code block update.

Overall, pharmacy operations continue to improve. 5.3 million prescriptions have been filled using the new EHR at the first five live sites from the VA CMOP since October 2020. This is in line with prescription fill volumes under VistA.

Upcoming Code Block 11:
Two times each year Oracle and VA provide major updates to the system to improve performance, add enhancements or customizations and make necessary software updates. Other times throughout the year updates are done in smaller batches termed "Cube Updates" or on a monthly basis. These updates are planned far in advance so that testing and validation can take place prior to installation.

In August 2024, the Code Block 11 update will be implemented to the EHR system. This update will include three modifications to the pharmacy module that will allow pharmacists to move faster in the application and one pharmacy supply chain enhancement to support more accurate accounting of medication lot numbers, thereby ensuring precise tracking of medication batches and reducing the risk of administering expired or recalled medications.

Block 11 will also include non-pharmacy related updates, including but not limited to:

- A pilot for an iOS app to be leveraged by Home Based Primary Care (HBPC) clinicians; and
- Enhancements to five existing interfaces in the new EHR to support workflows in Capacity Management, Dentistry, Prosthetic and Sensory Aids Service (PSAS), Telehealth, and Identity and Access Management.

In addition, we anticipate Block 11 to deliver even better performance and reliability improvements resulting in increased efficiency and improved user experience.

Cybersecurity/Cloud:
Cybersecurity is a top focus for Oracle. The security of our systems and our customers' data is a core competency of Oracle, which we have architected into our systems from the ground up. Oracle has decades of experience securing mission critical systems around the world.

Discussions to move the entire federal enclave to Oracle Cloud Infrastructure (OCI) continue with VA, DoD, and other federal parties. Oracle has committed to making this move to OCI at our expense.

Hosting the EHR on OCI will enable greater stability and reliability as the number of EHR users grows, and strong cybersecurity protections. Within the U.S. government federal space, Oracle holds a number of DOD security accreditations and FedRAMP authorizations, and we are an approved vendor under the Intelligence Community's Commercial Cloud Enterprise (C2E) program and the DoD's Joint Warfighting Cloud Capability (JWCC) program.

OCI was built with its foundation in scalability and security, which is fully integrated with features such as bastions for zero trust access, security zones for compartmentalized workloads and integration of security across the Infrastructure, Database and Application Layers.

Moving to OCI will provide even better protection against future threats, and we hope to eventually receive authorization from VA and DoD to make this happen.

Innovation:

The VA signed its agreement with Cerner in 2017. Since then, the technology has significantly evolved, and since Oracle's acquisition of Cerner, we have made strategic investments to advance the EHR – enhancing the user experience, efficiency, quality, and outcomes.

Most recently, Oracle released the Clinical Digital Assistant or CDA, which is a voice-first mobile assistant that can help lower documentation time on a computer and enable providers to spend more time with patients. CDA uses speech, language, and generative AI capabilities to enhance clinical end user workflows, and it is directly integrated into the EHR. Based on the encounter, it will produce a draft note and orders for further patient treatment, for the provider to edit and sign.

In the commercial setting, CDA has been met with wide approval and excitement because it is saving providers time and enabling them to have better engagements with their patients. This is an early example of the power of secure AI to support healthcare providers, and early adopters report "game-changing" results, saving 20-40 percent in documentation time. Working with VA for appropriate permissions, this is the future EHR that Oracle intends to bring to the EHRM program. We believe it will address many provider concerns – supporting experiences personalized to the physician's work and their individual style, reducing documentation burden, and enabling them to regain time for their patients and themselves.

Oracle also has provided VA with an update on all of our upcoming innovations to be considered for integration, including the Oracle Health Patient Administration Systems (PAS) that provides significant improvements in usability and interoperability for front-desk and patient self-service workflows; enhancements to documentation, condition management, medication ordering and referral management aimed at improving care teams efficiency and end user experience; and an expanded set of Fast Healthcare Interoperability Resources (FHIR)-based application programming interfaces to advance interoperability.

Next Steps

The eventual exit of the reset and beginning of pre-deployment work will not mean that further work to improve the EHR will end. That work will continue in parallel and given that it takes over a year from beginning pre-deployment work to the actual go-live, the next deployment will undoubtedly benefit from even more improvements that will take place.

Closing

Oracle is proud to continue working with VA to modernize its EHR system, and we are confident that the EHRM program is ready to restart deployment work soon and on a much more solid footing than ever before. We are steadfast in our mission to serve our nation's veterans through this project. Thank you and I look forward to answering your questions.